DISSERTATION
ON

"A STUDY TO ASSESS THE EFFECTIVENESS OF ART THERAPY AMONG PARANOID SCHIZOPHRENIA CLIENTS AT INSTITUTE OF MENTAL HEALTH, CHENNAI"

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In Partial fulfillment of requirements for the degree of

MASTER OF SCIENCE IN NURSING

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CERTIFICATE

This is to certify that this dissertation titled **"A study to assess the effectiveness of art therapy among paranoid schizophrenia clients at Institute of Mental Health, Chennai"** is a bonafide work done by Mrs. P.Yamunadevi, II year, MSc. (N) student, College of Nursing, Madras Medical College, Chennai-03 and submitted to **The Tamilnadu Dr. M.G.R. Medical University,** Chennai in partial fulfillment of the University rules and regulations towards the award of the degree of Master of Science in Nursing Branch- V, Mental Health Nursing under our guidance and supervision during the academic period, 2014 – 2016.

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Dissertation
on
A study to assess the effectiveness of art therapy among paranoid schizophrenia clients at institute of mental health, Chennai.

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"It is better to be hated for what you are,

Than to be loved for something you are not"

~ Andre Gide

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ABSTRACT

Title:

A study to assess the effectiveness of art therapy among paranoid schizophrenia clients at Institute of Mental Health, Chennai.

There is a paucity of literature on art therapy for paranoid schizophrenia on improving mental status, revealing on need for additional research. The present study examines the effectiveness among paranoid schizophrenia. The program uses art therapy techniques in helping paranoid schizophrenia clients to draw and color with coloring materials like crayons, paintings etc. to reduce psychiatric symptoms through ventilation of inner feelings.

Need for the study:

The process of making images plays a central role in the context of the psychotherapeutic relationship. The average life expectancy of people with this disorder is 10 to 25 years less than average life expectancy.

Objectives:

- To identify the socio demographic variables of the paranoid schizophrenia clients at Institute of Mental Health.
- To assess the pretest level of psychiatric symptoms among paranoid schizophrenia clients before art therapy.
- To evaluate the posttest level of psychiatric symptoms among paranoid schizophrenia clients after art therapy.
- To determine the effectiveness of art therapy among paranoid schizophrenia clients by comparing the pre test and post test levels of psychiatric symptoms among paranoid schizophrenia clients.
- To find a significant association between the posts test scores of psychiatric symptoms of paranoid schizophrenia clients with selected demographic variables.

Methodology

- Research approach: Quantitative approach
- Study design: One group pretest -- post test pre experimental design.
- Study settings: Inpatient wards in Institute of Mental Health.
- Study population: Paranoid schizophrenia clients.
- Sampling technique: Convenient sampling technique.
- Sample**:** Size (n=50).

Data collection procedure: The selected samples were assessed for the pre-existing level of psychiatric symptoms by using Basic Psychiatric Rating Scale questionnaire. After the pre-test, art therapy was intervened with the provided art materials daily half an hour for 10 days. On the 10^{th} day, the post-test was conducted by using the same questionnaire.

Data analysis and interpretation: Demographic variables and clinical variables were analyzed by using descriptive statistics (frequency, mean, and standard deviation) and with inferential statistics (chi-square test and student "t" test).

Result: The study shows in pre-test, the clients have 119.04 of BPRS score and in post test, they have 70.76 BPRS score, so the difference is 48.28. **(28.7**%) revealed that art therapy was effective and helped the paranoid schizophrenia clients in reducing psychiatric symptoms. There was a statistical significant difficult between pr and post test levels of psychiatric symptoms.

Discussion: Art therapy has been widely used as an adjunctive treatment for people with paranoid schizophrenia improves positively the quality of individual's life and their ability to recover from mental illness.

Conclusion: this study concluded that the reduction in psychiatric symptoms reflects the effectiveness of art therapy. So the nurses can educate the clients to practice at home and it is feasible and cost effective therapy.

Key words: Art therapy, psychiatric symptoms**,** paranoid schizophrenia.

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LIST OF ABBREVIATION

Abbreviation	Expansion
BPRS	Basic Psychiatric Rating Scale.
X^2	Chi square test
CI	Confidence interval
SD	Standard deviation
UK	United Kingdom
NICE	National Institute for Health and Clinical Excellence
MATISSE	Multi Centre Study of Art Therapy in Schizophrenia Systemic Evaluation.
IMH	Institute of Mental Health
DF	Degree of freedom
P	Probability
Vs	Versus
ES	Effective size
AJGP	American Journal of Geriatric Psychiatry.

CHAPTER-I

INTRODUCTION

"Art washes from the soul the dust of everyday life." ~ Pablo Picasso

Mental health is a state of balance between the individual and the surrounding world, a state of harmony between oneself and others, coexistence between the realities of the self and that of other people and the environment.

Mental health is defined as an adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. **(Karl Menninger 1947).**[1]

Mental illness is maladjustment in living. It produces a disharmony in the person's ability to meet human needs comfortably or effectively and function within a culture.

Mental and behavioral disorders are understood as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behavior associated with personal distress an impaired functioning. **(WHO 2010).**[1]

The unique concept about mental illness among the universe is difficult because of the cultural factors and is always puzzled, fascinated or a frightened one for those who do not understand. Knowledge and understanding of mental disorders has grown remarkably over the past century.[2]

Of all the mental illnesses responsible for suffering in society, Schizophrenia is the most tragic and devastating disease and the leading cause for disability among young adults[2]. Schizophrenia strikes at a young age so that, clients with schizophrenia usually live many years after onset of the disease and continue to suffer its effects, which prevent them from leading fully normal lives.

Schizophrenia is divided into subtypes based on the "predominant symptomatology at the time of evaluation." Paranoid type schizophrenia is a lifelong illness, but with proper treatment, a person suffering from the illness

can live a higher quality of life[3]. Social impairment may be minimal, and there is some evidence that prognosis, particularly with regards to occupational functioning and capacity for independent living, is promising**. (Mayo foundation for Medical Education and Research 2013).**

In worldwide

- There is an estimation of 1.5 million / year has been diagnosed as paranoid schizophrenia.
- About 0.3 to 0.7% of people are affected during their life time with paranoid schizophrenia.
- In 2014 there was estimated to be 23.6 million cases globally.
- The average life expectancy of people with this disorder is 10 to 25 years less than average life expectancy.
- Paranoid schizophrenia not only influences the lives of those affected but also those around them.

In India according to the survey of national mental health programme

- **In 2014** life time prevalence rate of paranoid schizophrenia has been identified as about 1 %.
- The incidence rate is about 4.2 /10, 000 populations.

Gender & Age:

- Equally prevalent in men and women.
- Onset is earlier in men than women.
- Peak age of onset is 10 to 25 years for men and 25 to 35 years for women.
- Onset before age 10 or after 60 is extremely rare.

According to the Mayo Clinic[5], it is best to start receiving treatment for paranoid schizophrenia as early as possible and is based on the types of symptoms that are exhibited in each individual case. The main options for the treatment of paranoid schizophrenia are Neuroleptics, psychotherapy, hospitalization, ECT, and vocational skills training.

Although treatment with antipsychotic drugs reduces the positive symptoms of schizophrenia and decreases the likelihood of relapse, it has little impact on negative symptoms.

Psychological and social interventions are widely used in combination with drugs in an effort to further improve the health and social outcomes of people with schizophrenia and several interventions have been shown to be effective**. (National Institute for health and Care Excellence 2007)[5].**

The possibility of involvement in art therapy has advantages over other treatments because the use of art materials can help people to understand themselves better while containing powerful feelings that might otherwise overwhelm them. (**Multicenter study of Art Therapy in Schizophrenia: Systematic Evaluation 2009)[6].**

Art therapy (AT) is a form of psychotherapy where the process of making images plays a central role in the context of the psychotherapeutic relationship. It has been widely applied to the treatment of mental health problems and across all spectra of severity. **(2013 Rebeca L. Toader)[8]**

Art therapy is not only used for person suffered with mental illness, but quietly for child, adult and adolescence who are suffering with personal problems related to growth and has been applied as both a short-term and a long-term intervention**.** (**Richardson, Jones, Evans, Stevens, and Rowe (2007)[11]**

1.1 Need for the study

According to **Thomas H. McGlashan, M.D., Director and Wayne S. Fenton, M.D.,[17]** Paranoid schizophrenia is a debilitating mental illness that affects 1 percent of the population in all cultures. It affects equal numbers of men and women, but the onset is often later in women than in men. Paranoid schizophrenia symptoms affect clients' families; therefore, it is important for physicians to provide guidance to all persons affected by the disease. Psychosocial and family interventions can improve outcomes.

In an article of (**Paul H Lysaker et al)**[15] recovery from paranoid schizophrenia has been conceptualized to involve subjective changes in how persons appraise their lives and the extent to which they experience themselves as meaningful agents in the world. Treatments with antipsychotic and many useful therapies have been developed to assist people with paranoid schizophrenia individual therapy, art therapy, cognitive remediation, family education, self help groups.

Art therapy is believed that the creative process involved in artistic self-expression helps people to resolve conflict and problems, develop interpersonal skills, manage behavior, reduce stress, reduce anxiety, and increase self-esteem for communication than simply having a conversation and talking about things. (**Karin Egberg)**[25],

The post graduate psychiatric nurse investigator during her clinical experience she observed that most of the mentally ill clients were more interested in doing art works and it provides an opportunity for them to communicate and ventilate their inner feelings. Especially the paranoid schizophrenia clients who have suspicious thoughts it was more expressive in their pictures. This makes the researcher to find that how much this art will help in the improvement of mental health.

1.2 Statement of the study:

"A study to assess the effectiveness of art therapy among paranoid schizophrenia clients at Institute of Mental Health, Chennai.

1.3 Objectives:

- To identify the socio demographic variables of the paranoid schizophrenia clients admitted at Institute of Mental Health.
- To assess the pretest level of psychiatric symptoms among paranoid schizophrenia clients before art therapy.
- To evaluate the posttest level of psychiatric symptoms among paranoid schizophrenia clients after art therapy.

- To determine the effectiveness of art therapy among paranoid schizophrenia clients by comparing the pre test and post test levels of psychiatric symptoms among paranoid schizophrenia clients.
- To find a significant association between the posts test scores of psychiatric symptoms of paranoid schizophrenia clients with selected demographic variables.

1.4 Operational definitions:

- **Assess:** refers to the process of revealing the progress in the normal mental function among the Paranoid schizophrenic clients[17].
- **Effectiveness:** refers to the extent to which art therapy has achieved the desired effect in terms of changes in psychotic symptoms of pre and post test score of the subjects studied[27].
- **Art therapy:** refers to a form of psychotherapy that uses art media (color pencils, crayons, sketch pens, rangoli powder, white papers, outlines of fruits, vegetables, rangoli designs, flowers, boys, girls, birds) as its primary mode of communication and the process of art making to improve and enhance the physical, mental and emotional well-being of individuals of all ages[25].
- **Paranoid schizophrenia:** Paranoid schizophrenia is a psychotic condition characterized by the delusion of persecution, suspicious, grandiosity, hallucinatory (auditory) in the presence of clear consciousness, leads to social withdrawal[10].
- **Psychiatric symptoms**: refers to the symptoms of disturbances in emotions, feelings, thoughts**,** behaviors etc[30].

1.5 Assumptions:

- Paranoid clients are more suspicious and they will not express their thoughts verbally.
- Art therapy will be helpful to communicate the inner feelings of the clients.

- Art therapy will be useful to improve the mental health of the paranoid clients.

1.6 Hypothesis

- **H_1:** Art therapy reduces psychiatric symptoms in paranoid schizophrenia clients.
- **H_2:** There is association between psychiatric symptoms among paranoid schizophrenia and the selected demographic variables.

1.7 Delimitation

- The study is limited to the period of four weeks.
- The population is restricted to the clients who have been admitted in Institute of Mental Health, Kilpauk, and Chennai.
- This study limited to the paranoid schizophrenia clients only.
- The clients who were diagnosed and on treatment for less than five years.

CHAPTER – II

REVIEW OF LITERATURE

This chapter gives the evidences for support of similar research findings which have been done earlier by other researchers over internationally and nationally.

2.1 Reviews related to the study

The supportive and relevant studies have been presented in the following views:

2.1.1. Section A studies related to the art therapy.

2.1.2. Section B studies related to treatment of schizophrenia.

2.1.3. Section C studies related to ART therapy in paranoid schizophrenia

2.1.1. Section A studies related to art therapy

Sunhee K. Kim (2013)[16] conducted a study on Korean American older adult population to investigate the effectiveness of art therapy on healthy aging in terms of its promotion of well being and a better quality of life. This study showed positive results and supports the hypothesis that the art therapy promoted healthy aging by reducing negative emotions, improving self esteem and decreasing anxiety.

Douglas Mitchell, LMFT 2012 revealed a result in research on depressive clients and proved that art therapy is a beneficial method of treating depression across a wide spectrum of personalities. Researcher observed something that they believed to be beautiful, the neuron transmitter dopamine located in one of their pleasure centers in the brain is released and increases the positive feelings when doing art works.

Geue –Kristina & et al (2012) researched a study on oncology clients at Information centre for Oncology clients at selected hospitals in New York, to found the gender difference of interest in participating art therapy sessions and the relationship in improvement of social adjustment, mental health and quality of life. But the results they found that women are more interested in participating art therapy sessions and there was no gender difference in the improvement of social adjustment, mental health, and quality of life among the oncology clients.

El SA Van den Broke 2011 conducted a randomized controlled pilot study to determine the effectiveness of art therapy and schema focused therapy of evoking emotional states in forensic clients at the prison. They investigated the effect of art therapies versus verbal psychotherapy, schema focused therapy on modes. The researchers found that there is a significant healthier emotional states in their art therapy than in verbal psychotherapy sessions and there is no differences in schema mode conditions.

Marie, MD; et al. Palliative & Supportive Care (2011) aimed to describe the art therapy intervention program on coping resources in women with primary breast cancer at Department of Oncology at Umeå University Hospital in Sweden postoperative radiotherapy unit with individual art therapy for one hour per week during postoperative radiotherapy and found that there was an overall increase in coping resources among women with breast cancer after taking part in the art therapy intervention.

Alex Mihalidis & et al (2010) looked at all the studies that researched art therapy for dementia clients. 12 different studies were included. The symptoms included psychological symptoms, some physical symptoms and some looked at the meaning of experiences of art therapy for people who took part. The researchers found that art therapy seemed to give some improvement in distress, depression, tiredness (fatigue), and general health.

Beebe,Anya, Gelfand et al (Journal of Allergy and clinical immunology 2010)[19] conducted a study among asthmatic children on copping chronic illness through art therapy at selected hospitals in Canada. By using pediatric quality of life scale and Beck anxiety Scale, and received the result that there is a benefit from art therapy that includes decreased anxiety and increased quality of life.

Crowford.M.J. (2010) conducted a study in Israel, for investigating the contribution of art therapy to the adjustment of children with learning disability and assesses interventions and their association with outcomes. This study compared the art therapy as an adjunct to academic assistance only. They found the results more favorable outcomes in adjustment under art therapy conditions and similar progress in academic achievement under condition. The results revealed very different that the academic intervention focused on improved learning experiences only. The art therapy intervention focused on the emotional exploration and awareness in insight development.

Epp, Kathleen Marie (2008) determined the social skills among autistic children in schools of Rodge field super kids' school. Connecticut. Using art therapy and cognitive-behavioral techniques in a group therapy format to broaden and deepen the state-of-the-art techniques and revealed a significant improvement in assertion scores, coupled with decreased internalizing behaviors, hyperactivity scores, and problem behavior scores in the students.

2.1.2. Section B studies related to paranoid schizophrenia:

Gerard E. Hogarty, Deborah Greenwald, (2014) studied on an individual psychotherapeutic approach to prevent relapse appears or lessen at the community level in Park town city, with 151 clients of schizophrenia who were discharged from the hospital over a period of 3 years living with family and independent of family produced a result of positive effect through personal

therapy among clients living with family and there was an increased rate of psychotic relapse for clients living independent of family.

Montag, Christiana & et al (2014) done a pilot study to evaluate the feasibility of an assessor - blind, psychodynamic art therapy for the treatment of clients with schizophrenia to generate data on efficacy of intervention during acute psychotic episodes and got the outcomes of there was a significant reduction in positive symptoms and improvement in psychosocial functioning at post treatment and follow up.

Charlotte E. Wittekind (2014) provided an article in British Journal of Psychiatry as a narrative review of emperical studies on meta cognitive training in schizophrenia, psychosis with positive symptoms, particularly delusions appears to be a worthwhile complement to pharmacotherapy especially effective in addressing symptoms, cognitive, biases and insight.

Douglas Turkington M.D., Peteer J. Weiden,M.D.(2013) evidenced that the cognitive behavior therapy with antipsychotic regiment in treatment of schizophrenia as a standard of care in United Kingdom and United States for the implementation at selected hospitals with large number of trials strengthened the successful outcomes of the results in acceptance as evidenced based treatment for medication resistant schizophrenia.

Rebeca L.Alina Gaboran (2013) in their study they identified that the clients suffering from paranoid schizophrenia have serious disturbances in ego development, self-esteem and self-identity, their graphic work reflecting the symptoms of their psychopathology.

Eric Hollander, M.D (2011)[16] showed the study on social anxiety in schizophrenia was associated with severe disability at Ludiana psychiatric hospital. By using social anxiety scale results that schizophrenia clients without social anxiety disorder had significant lower scores that with groups of schizophrenia with social anxiety disorders**.**

[Wayne S. Fenton, (2011)] done a research on schizophrenia clients to find the paradigms in psychotherapy versus medication or supportive therapy versus investigative treatment and finally observed the results in various stages that there was an improvement in self awareness and self cognition responses are very good in treatment with psychotherapy and supportive therapy clients shows improvement in social skills.

Carol S. et.al. (2008) study is literature life events with stressful effect are significant both for initiation and progress of the schizophrenia. Having this in mind we set our aim to be investigating the relationship between life events (considered as stressful), sex and age trough questioning 50 clients with paranoid schizophrenia. The results of our study showed presence of correlation between some of the studied life events, assessed as stressful. The analysis of the data revealed that both sex and age are influencing the assessment of the significance of the life events and "increases" their importance both for women and men.

Also, according to **Crawford (2007),** the goal of art therapy was to aid in self-expression, promote self-awareness and increase insight, thus enhancing the person with paranoid schizophrenia's overall well being.

The British Journal of Psychiatry Jul (2007)[14] conducted a study to appraise the usefulness of symptom rating scales in evaluating the outcome of people with schizophrenia Scales were designed to make diagnoses, to categorize clients, syndromes or both, and to demonstrate antipsychotic efficacy, as well as to measure outcome. There is much redundancy both between and within scales. The concept of remission, which uses absolute item score thresholds with a duration criterion, is a promising outcome measure.

Thoma, Weibel and Daum (2007) they believed that higher incidents of unemployment, homelessness, and shorter life span affects the common

function in the brain of both substance abuse and paranoid schizophrenia has been the dysregulation of dopamine in paranoid schizophrenia and elevated activity in dopaminergic activity to achieve the level of reinforcing affects in the dual diagnosed schizophrenics. Positive symptoms, such as hallucinations and disorganized thoughts were higher in dual diagnosed schizophrenics. Negative symptoms, such as anhedonia, were reported lower than in non-substance using schizophrenics.

(Evan 2007) According to the literature life events with stressful effect are significant both for initiation and progress of the schizophrenia. Having this in mind the investigators found the relationship between life events (considered as stressful), sex and age trough questioning 50 clients with paranoid schizophrenia. The results of our study showed presence of correlation between some of the studied life events, assessed as stressful. The analysis of the data revealed that both sex and age are influencing the assessment of the significance of the life events and "increases" their importance both for women and men.

2.1.3. Section C studies related to ART therapy in paranoid schizophrenia

Crawford. M. J. (2011) conducted a study to evaluate the clinical effectiveness of group art therapy for people with paranoid schizophrenia and to test whether any benefits exceed those of active participants were selected randomly and tested for 12 months of weekly art therapy plus standard care. In art therapy members were encouraged to express themselves freely with the provided out materials and found that their attendance level in attending the therapy sessions was good.

Honig (2010) described working with regressed clients and found that the best approach was one that was reality based, such as depicting the human figure, landscapes or ordinary objects. The goal of the session was to give confidence to the patient and create a trusting relationship between patient and

therapist. The use of a confrontational approach in art therapy could open verbal communication, as well as lead the way for self-actualization. There were three areas of importance when working with this population that being the symptoms of the patient, the overall characteristics of their art work, and then the art therapy technique she used with them.

In Schizophrenic Art, Naumburg (2007)[17] wrote about the ability of the patient to express him or herself in art thus gaining ego strength. Using spontaneous art expression the clients found their way to the source of their conflicts. This approach could be used with persons who have paranoid schizophrenia who were able to respond quickly to the spontaneous art therapy approach, but not with the chronic, regressed or deeply psychotic clients.

Richardson et al, (2007). highlighted that art therapy can help modify psychotic projections, the use of art therapy in conjunction with traditional forms of treatment being an effective tool in treating the paranoid schizophrenic patient. Clients were assessed on a range of measures of symptoms, social functioning and quality of life at pre- and post- treatment and six months follow-up. Results showed that art therapy produced a statistically positive effect on negative symptoms, assed by Scale for the Assessment of Negative Symptoms.

In a study by **Richardson, Jones, Evans, Stevens, and Rowe (2007)** the usefulness of art therapy for treating paranoid schizophrenia was explored. In a short-term pilot program lasting only 12 sessions, the findings were significant in treating the negative symptoms such as anhedonia, or lack of emotion, in people with paranoid schizophrenia. Art therapy has been used in the treatment of paranoid schizophrenia since its inception.

Heenan, (2006). Art therapy has been widely used as an adjunctive treatment for people with paranoid schizophrenia, affecting positively the quality of individual's life and their ability to recover from mental illness.

Many quantitative studies reveal significant data regarding the effectiveness and implementation of art therapy, but their effective implementation requires in depth exploration of patient's interpretations and perceptions. Understanding the inner world of the patient is indispensable because it influences the illness related behavior and treatment adherence..

In **Wadeson's (2005)** work with chronic schizophrenic clients who lacked insight, her own goals for the therapy were for her to be in the moment emotionally, to be supportive and provide continuity of the art therapy in hopes of the client having insight in the future.

[Sarah C. Slayton and et al (2000)] n their article they identified the measured outcomes of art therapy effectiveness with all ages of clinical and nonclinical populations**.** Although numerous studies blend art therapy with other modalities, this review is limited to studies that isolate art therapy as the specific intervention. The results of this review suggest that there is a small body of quantifiable data to support the claim that art therapy is effective in treating a variety of symptoms, age groups, and other demographic variables.

2.2 Conceptual Framework

This study was based upon Wiedenbach's helping art of clinical nursing theory. The central purpose of this theory refers to the nurse's desires to accomplishment. A nurse develops a prescription based on the central purpose and implements according to the reality of the situation.

The main concept of this theory were

- ✓ **Identifying the need for a help.**
- ✓ **Ministering needed help.**
- ✓ **Validating that need for help was met.**

Step I: Identifying need for help:

It involves viewing the patient as an individual with unique experiences. Determining a patient's need for help is based on the existence of a need whether the patient realizes the need and what prevents the patient from meeting the need. In this study it refers to the assessment of level of mental functions by using BPRS among paranoid schizophrenia clients before administering art therapy.

Step II: Ministering the needed help:

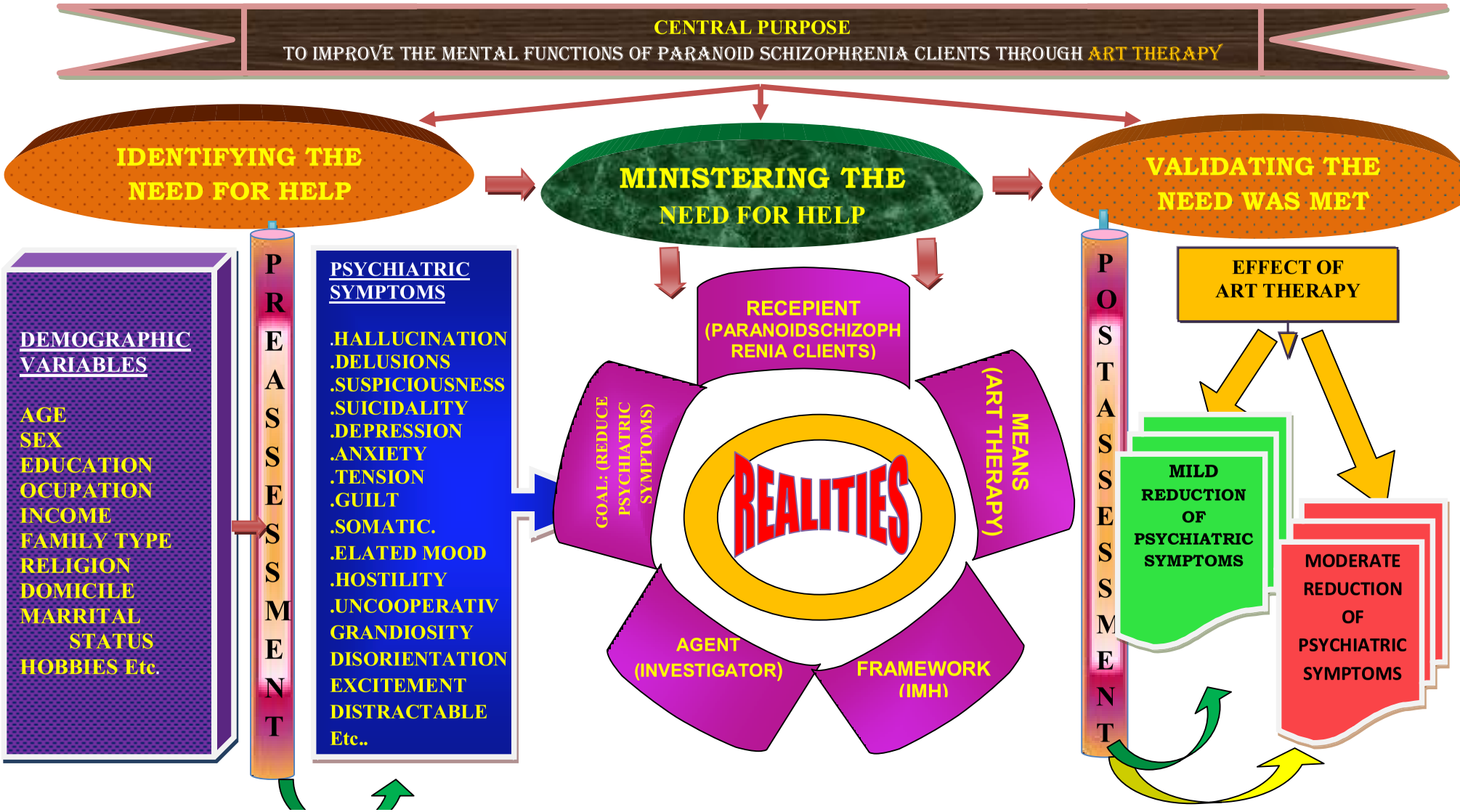
It means the provision of needed help. This requires an identified need and a patient who wants help. In this study it refers to ministering art therapy to the paranoid schizophrenia clients. This will be administered to the individual client. Realities in ministering the need for help include the following:

1. Goal: reduce the psychiatric symptoms of paranoid schizophrenia clients.
2. Framework: selected wards in Institute of Mental Health
3. Means: art therapy
4. Agent: the investigator
5. Recipient: paranoid schizophrenia clients.

Step III: Validating that a need for help was met:

It means evaluation of the level of psychiatric symptoms by using BPRS and also evaluating the improvement in emotional and psychological well being, recalling the past memories by means of relaxation, self expressions, and communicating their inner feelings. Reassessment of psychiatric symptoms level is done when it is needed.

FIG.2.1.MODIFIED WEIDENBACH'S HELPING ART OF CLINICAL NURSINIG THEORY



CHAPTER-III

METHODOLOGY

This chapter deals with the research design, define specific methods, even though much attention is given to the nature and kinds of processes to be followed in a particular procedure or to attain the objectives here the variable of the study, setting, the population, sample, sampling technique, selection criteria and description of tool, content validity, pilot study, reliability and plan for data analysis. c

3.1. Research approachar

Quantitative approach.

3.2. Study design

Pre-experimental design one group pre test & post test design[23].

Table 3.1 Schematic presentation of research design

Group	Pre test	Intervention	Post test
Experimental	01	X	02

Key:

01 – Psychiatric symptoms of paranoid schizophrenia clients before art therapy.

X -- Administration of art therapy.

3.2.1. Intervention protocol:

Place: Inclients Wards in Institute of Mental Health**.**

Intervention: Art Therapy.

The intervention of art therapy has been provided with the use of art materials like plain white papers, color charts in various sizes and the drawing materials like color pencils, crayons, sketches, paints, and also color powders. With that some outlined pictures of fruits, vegetables, flowers, rangoli designs, natural sceneries, cartoon pictures, color chalks, etc.

Client has been given choice to select their own choice of pictures and art materials and make them to color or draw with variety of options for half an hour daily for 10 days.

Tool: Basic psychiatric rating scale

Duration: 10 days

Time: Half an hour daily per patient.

Frequency: Once daily.

Recipient: Paranoid schizophrenia clients.

Administrator: Investigator

02 – Psychiatric symptoms of paranoid schizophrenia clients after art therapy.

3.3. Study settings

Psychiatric inpatient wards at Institute of Mental Health, Chennai. Institute of Mental Health involved in Mental Health care for the past 210 years. It was founded in 1794 as an Asylum to manage only 20 in clients. Now it has grown up to an Institute with 1800 Inpatient. In 1922 it became Govt. mental hospital. In 1948 the census has gone up and official bed strength was regularized. In 1978 it was renamed as Institute of Mental Health attached as a teaching institute with Madras Medical College. Today it is the second largest Institute in India. It has been well established with all special services like rehabilitation, industrial, occupational, recreational family yoga etc. And there are separated areas for male and female clients.

3.4. Data collection period

Four weeks (16.07.2015 to 14.08.2015).

3.5. Study population

The target population of the study was the clients diagnosed and admitted as paranoid schizophrenia at acute and chronic male and female wards at Institute of Mental Health, Chennai.

3.6. Sample size

Sample size (N) = 50

3.7. Sampling criterion

The sample for this study constitutes the paranoid schizophrenia clients admitted and residing in the hospital for less than five years of treatment for the paranoid schizophrenia complaints.

3.7.1. Inclusion criteria:

1. Clients diagnosed as paranoid schizophrenia.
2. Clients who are accepting to draw and coloring the picture.
3. Clients who are willing to participate in the study.
4. Clients who speaks and understands Tamil.

3.7.2. Exclusion criteria:

1. Clients who are not interested in drawing.
2. Clients who are in the state of aggression.
3. Clients who are in the treatment for more than 5 years.
4. Clients with co-morbid illnesses.
5. Clients who are below twenty years and above sixty years.

3.8. Sampling technique

Convenient sampling technique.

3.9. Research variables:

Independent variable : Art therapy. By means of crayons, color pencils, sketches, color chalks, rangoli powders.

Dependent variable : Psychiatric symptoms of paranoid schizophrenia clients.

3.10. Development and description of the tool:

3.10.1. Development of the tool

The extensive literature review and discussion with experts, the investigator selected the scale to assess the psychiatric symptoms among the paranoid schizophrenia clients.

3.10.2. Description of the tool

The tool consists of section A and B:

1) **Section A: Socio demographic data**

   It consists of data such as age, gender, education, occupation, income, religion, locality, marital status, family type, and hobby.

2) **Section –B: Standardized tool to assess the psychiatric symptoms of paranoid schizophrenia clients.**

   The Brief Psychiatric Rating Scale (BPRS)[20,22] is a widely used instrument for assessing the positive, negative, and affective symptoms of individuals who have psychotic disorders, especially schizophrenia. It has proven particularly valuable for documenting the efficacy of treatment in clients who have moderate to severe disease.

   It should be administered by a clinician who is knowledgeable concerning psychotic disorders and able to interpret the constructs used in the assessment. Also considered is the individual's behavior over the previous 2-3 days and this can be reported by the patient's family.

   The BPRS consists of 24 symptom constructs and takes 20-30 minutes for the interview and scoring. The rater should enter a number ranging from 1 (not present) to7 (extremely severe). 0 is entered if the item is not assessed.

   First published in 1962 as a 16-construct tool by Drs. John Overall and Donald Gorham, the developers added two additional items, resulting in the 18-item scale and further 6 more items were added and used widely today to assess the effectiveness of treatment

The tool consists of the 24 symptoms of psychiatric clients. Rate items 1-14 on the basis of individual's self-report. Note items 7, 12 and 13 are also rated on the basis of observed behaviour. Items 15-24 are rated on the basis of observed behaviour and speech.

Scoring instructions

Table 3.2. Scoring instructions

0	**Not assessed,**
1	**Not present,**
2	**Very mild,**
3	**Mild,**
4	**Moderate,**
5	**Moderately severe,**
6	**Severe,**
7	**Extremely severe**

Table 3.3. Score Interpretation

Minimum score = 1 Maximum score =7 Questions= 24 Total score=168

S no.	**Grade**	Score
1.	Mild	≤ 84
2	Moderate	85 -126
3	Severe	> 126

Sum the scores from the 24 items. Record the total score and compare the total score from one evaluation to the next as the measure of response to treatment.

3.11. Ethical consideration

The study objectives, intervention procedures, data collection procedures were approved by the research ethics committee, Madras Medical College. Necessary permission to conduct the study was requested and obtained from The Principal, College Of Nursing, Madras Medical College, Head of Department, Mental Health Nursing, College Of Nursing, Madras Medical College. The study was done without any violation of human rights.

3.12. Content validity of the tool

Content validity of the tool was assessed by obtaining opinion from experts in the field of psychiatric nursing, psychiatrist and psychologist, statistician and the therapist. There was a uniform agreement to the tool adopted for conducting the study. Hence, the investigator proceeds with the same tool.

3.13. Pilot study

The feasibility of the study was assessed by conducting the pilot study (from 22.06.2015 to 27.06.2015). The pilot study was conducted with 10 samples that fulfilled the sampling criteria, were selected by non probability convenient sampling technique. The purpose of the study was explained to the samples and then consent obtained from them. The study was conducted with the tool on demographic data, standardized tool (BPRS score)on assessment of psychiatric symptoms. Data was analyzed by using descriptive statistics. The pilot study elicited that the study was feasible.

3.14. Reliability of the tool

After pilot study, the reliability of the tool was assessed by using split half method. BPRS score reliability correlation coefficient (r) value was 0.79. This correlation coefficient is very high and it is good tool for assess the effectiveness of art therapy among paranoid schizophrenia clients at institute of mental health, Kilpauk, Chennai.

3.15. Data collection procedure

The study was conducted at Institute of Mental Health, Chennai. A formal permission was obtained from the Director of IMH. The investigator obtained data from the paranoid schizophrenia clients who were admitted in the acute and chronic wards of IMH. The main study was conducted for the period of 4 weeks from 16.07.2015 to 14.08.2015. initially the investigator approaches the clients who were already admitted and staying in the inpatient (male) totally she selected 20 clients. From them 5 were not interested in doing art and other 15 clients were interested in drawing. So the informed consent were obtained from them, pretest test was conducted and the art therapy was given according to their own choice (color chalks, outlined pictures, crayons, color pencils, sketches) those 15 people has been divided in to 5 groups and in each group 3 clients were sit on the same room but the intervention has been given as individual. The groups were divided for the convenience of the investigator for supervision. Art therapy has been continued for 10 with daily half an hour to forty five minutes, at the 10^{th} day post test was conducted by using BPRS score.

The same procedure was followed in the female wards the investigator selected 28 female clients 2 of them is not interested and 4 of them was unable to continue their intervention because of their physical illness. So remaining 22 clients were divided in to 7 groups and the intervention continued for 10 days after obtained consent and pretest and post test were conducted. The pilot study samples were excluded in this main study.

Finally the remaining clients were selected from the acute male and female wards according to the admission 15 more clients were selected and 1 was discharged during the procedure and 2 of them unable to continue due to aggressiveness the balance 13 clients were continued with 10 days intervention and the post test was conducted.

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3.16. Data entry and analysis

The data collected from the selected samples in the period of data collection has been organized, compiled and coded separately in excel sheet as

- ✓ Demographic variables in categories were given in frequencies with their percentages.
- ✓ BPRS score were given in mean and standard deviation.
- ✓ Association between demographic variables and level of BPRS gain score were analysed using chi-square test
- ✓ Pretest and posttest knowledge score were compared using student's paired t-test.
- ✓ Differences between pretest and posttest score was analysed using proportion with 95% CI and mean difference with 95% CI.

  Simple bar diagram, multiple bar diagram, Doughnut diagram, Pie diagram and Box plot were used to represent the data.
- ✓ $P<0.05$ was considered statistically significant. All statistical tests are two tailed test

FIG.3.1.SCHEMATIC REPRESENTATION OF THE STUDY

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

Doubt is not a pleasant condition, but certainty is absurd.

-Voltaire (French humanist)

This chapter deals with the analysis and interpretation of the data obtained from 50 paranoid schizophrenia clients who were admitted in Institute of Mental Health, Chennai – 10. The collected data were tabulated and presented according to the objectives under the following headings:

Section I **:** Socio demographic profile of the paranoid schizophrenia clients.

Section II **:** Level of psychiatric symptoms before art therapy intervention.

Section III **:** Level of psychiatric symptoms after art therapy intervention

Section IV **:** Effectiveness of the art therapy

Section V **:** Associate the effectiveness of art therapy with selected demographic variables.

Section I :Socio demographic profile of the paranoid schizophrenia clients.

Table 4. 1: Distribution of Socio demographic profile of the paranoid Schizophrenia clients.

Demographic variables			Frequency	In %
1.	Age	21 -30 years	4	8
		31 -40 years	28	56
		41 -50 years	16	32
		51 -60 years	2	4
2.	Gender	Male	17	34
		Female	33	66
3.	Education	No formal education	8	16
		Schooling	17	34
		Graduate	20	40
		Post graduate	5	10
4.	Occupation	Labor	10	20
		Private company	18	36
		Government	10	20
		Business	12	24
5.	Monthly Income	< Rs.6000	4	8
		Rs.6001 - Rs.10,000	26	52
		Rs.10,001 - Rs.15,000	14	28
		> Rs.15,000	6	12
6.	Religion	Hindu	21	42
		Muslim	19	38
		Christian	9	18
		Others	1	2
7.	Residence	Urban	40	80
		Rural	10	20
8.	Marital status	Single	20	40
		Married	24	48
		Widowed	5	10
		Divorced/separated	1	2
9.	Type of Family	Nuclear family	33	66
		Joint family	16	32
		Extended family	1	2
10.	Hobby	Music	15	30
		Reading	18	36
		Drawing	7	14
		Others	10	20

The above table shows the demographic information of clients those who are participated for the following study on "A study to assess the effectiveness of art therapy among paranoid schizophrenia clients at institute of mental health, Chennai".

Among the paranoid schizophrenia clients,

Age wise: About 8% in the age group of **21-30 years**, higher proportion 56% in the age group of 31 -40 years, 32% were in 41- 50 years, minimum 4% were 51-60 years.

Gender wise: About 66% of them were female and remaining 34% were male.

Education status: About 40 % were **graduates,** 10% were postgraduates and 34% have school level education other 16% had no formal education.

Occupation: About 20% were laborer and Government job, whereas 36% were going for p**rivate job** and other 24% were doing business.

Monthly income: Among the study participants 52% were earning **Rs.6000- 10,000 per month**, and 12% of them were earning more than Rs.15000, 28% of them earn Rs.10,000 – 15,000 and 8% of them were under the earning of less than Rs.6000/-.

Religion: About 42% were **Hindu**, 38% were Muslims, and 18% were Christians, and 2% belongs to other religion.

Residence: Among them 80% were living in **urban** area and20% were in rural.

Marital status: Forty eight percent of the study populations were **married**, 40% were living single and 10% were widowed and 2% were divorced or separated.

Type of family: About 66% were living in **nuclear family type**, and 2% only living in extended family and the balance 3% were living in joint family.

Hobby: Most of them were interested in **reading** books and 30% were interested in listening music and only 14% were interested in drawing and other 20% were interested in watching movies and tailoring etc.

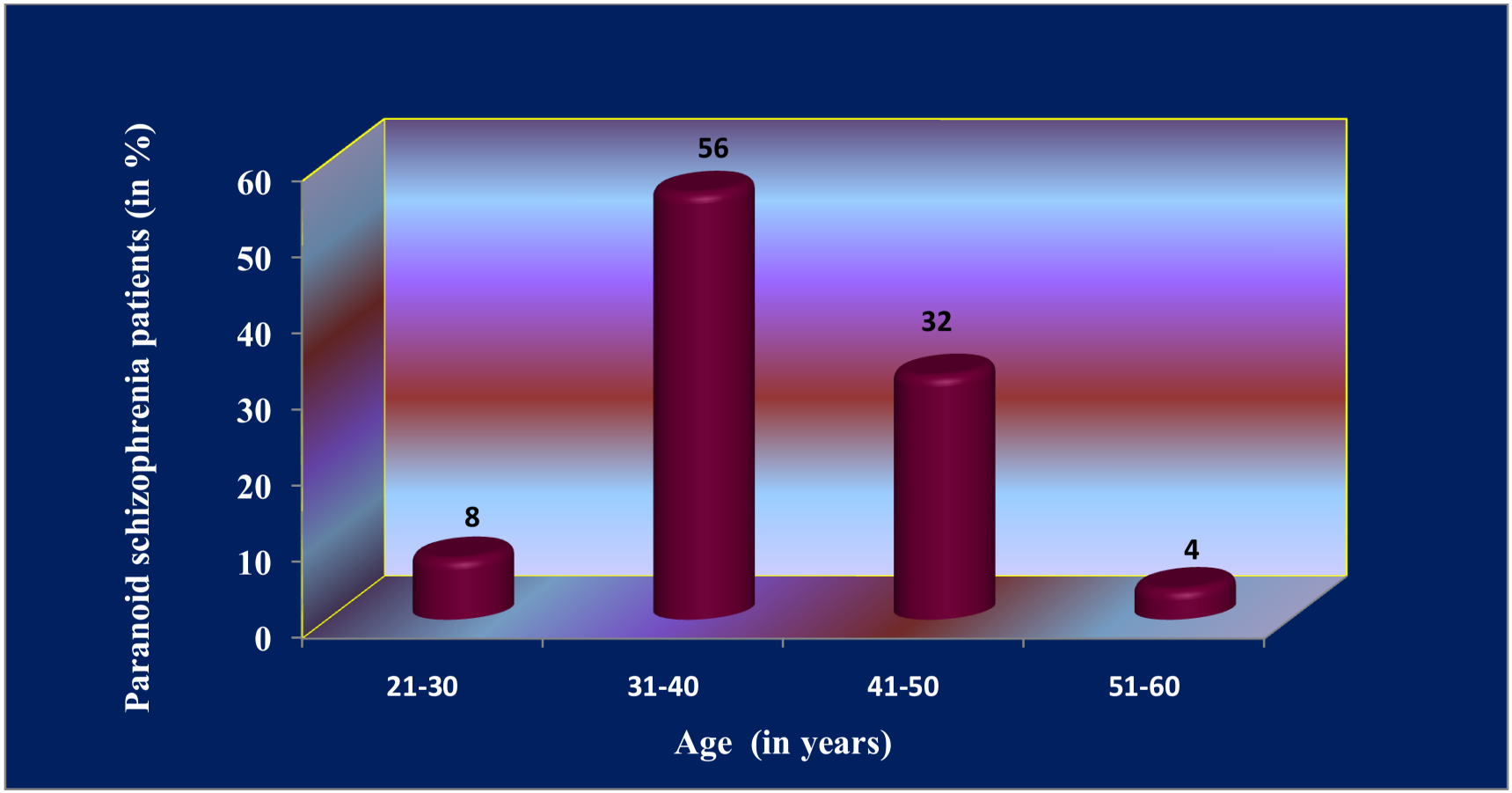

Fig.4.1. Age wise distribution of paranoid schizophrenia clients

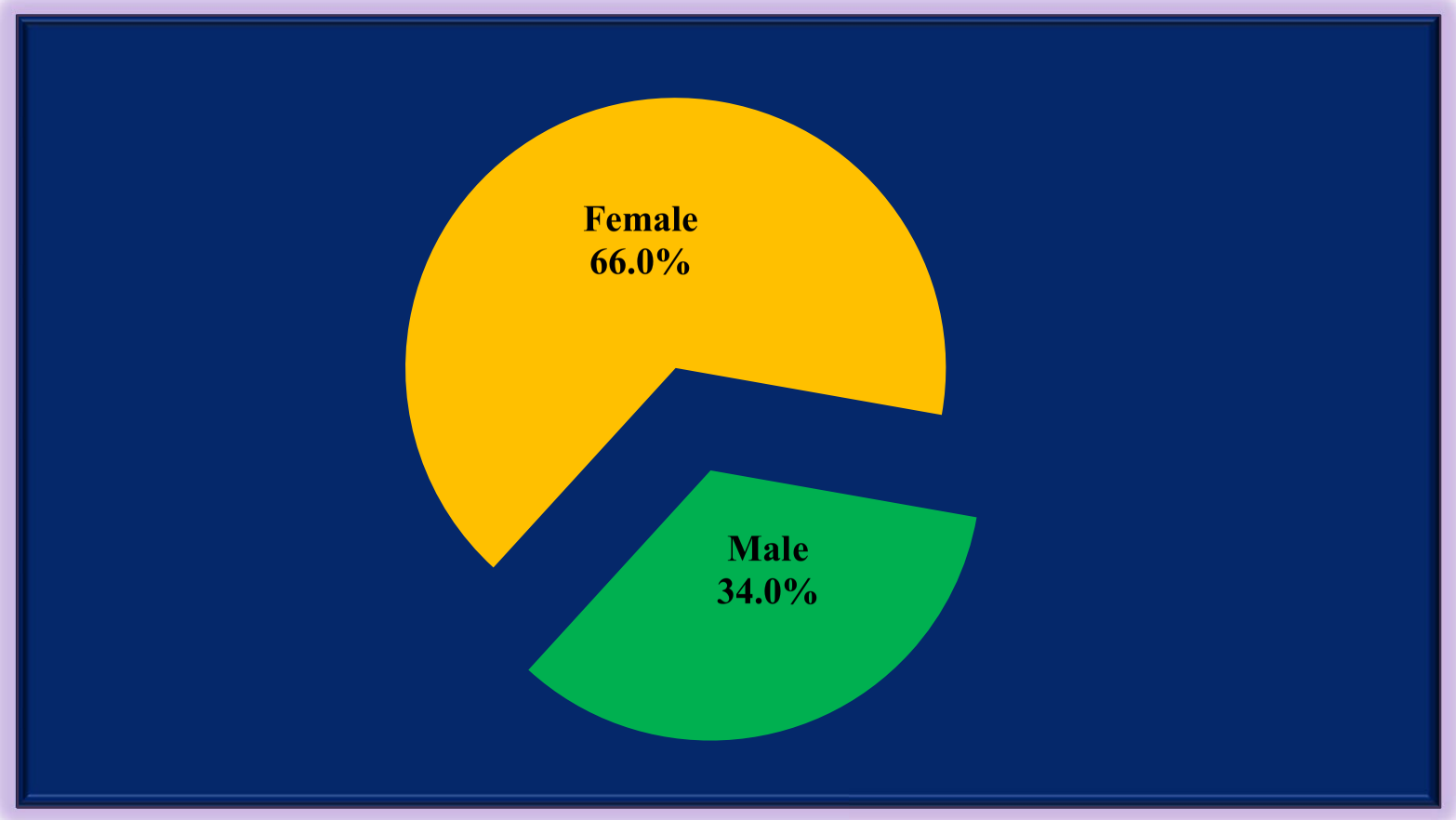

Fig.4.2.Gender wise distribution of paranoid schizophrenia clients

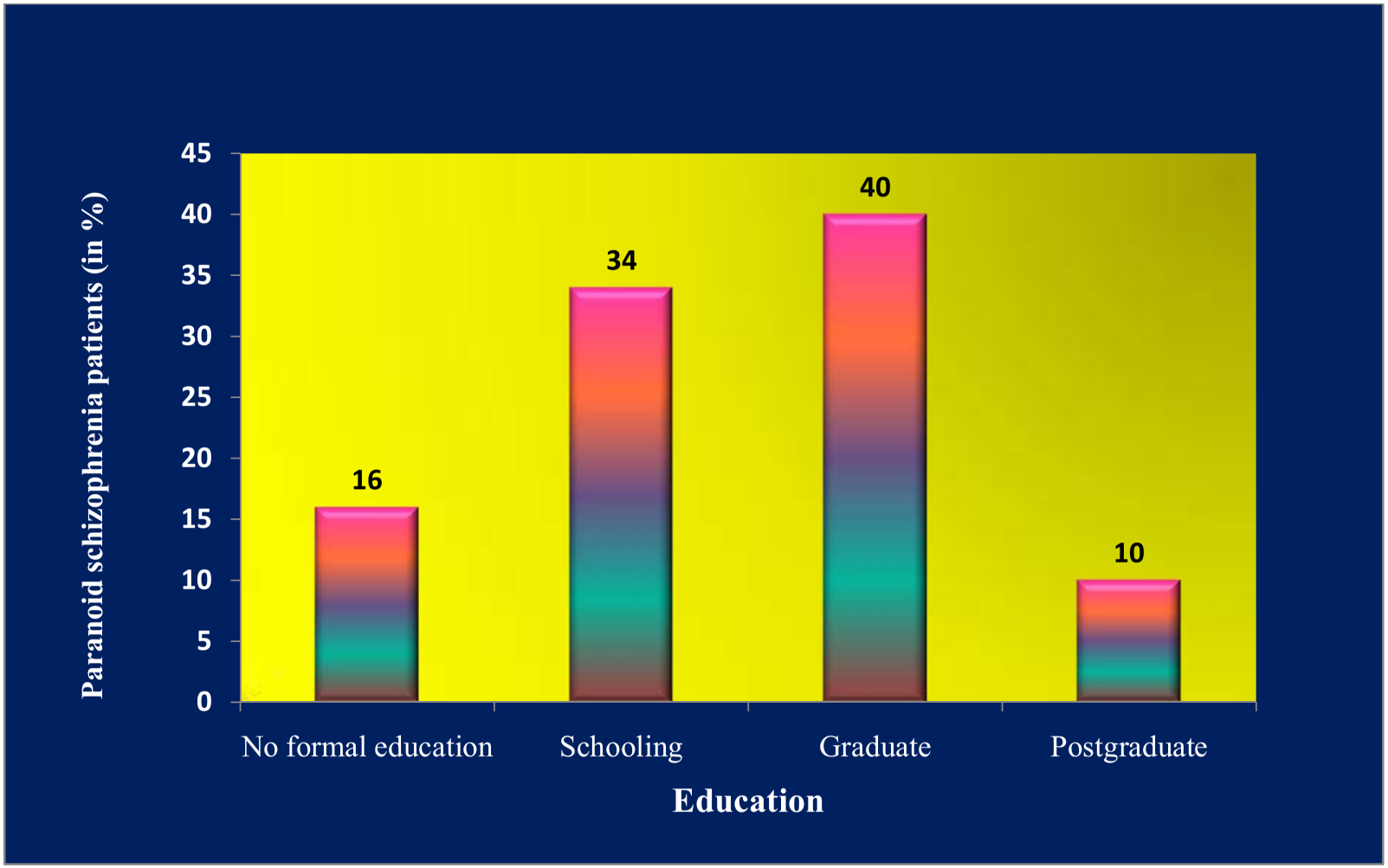

Fig.4.3. Educational status of paranoid schizophrenia clients

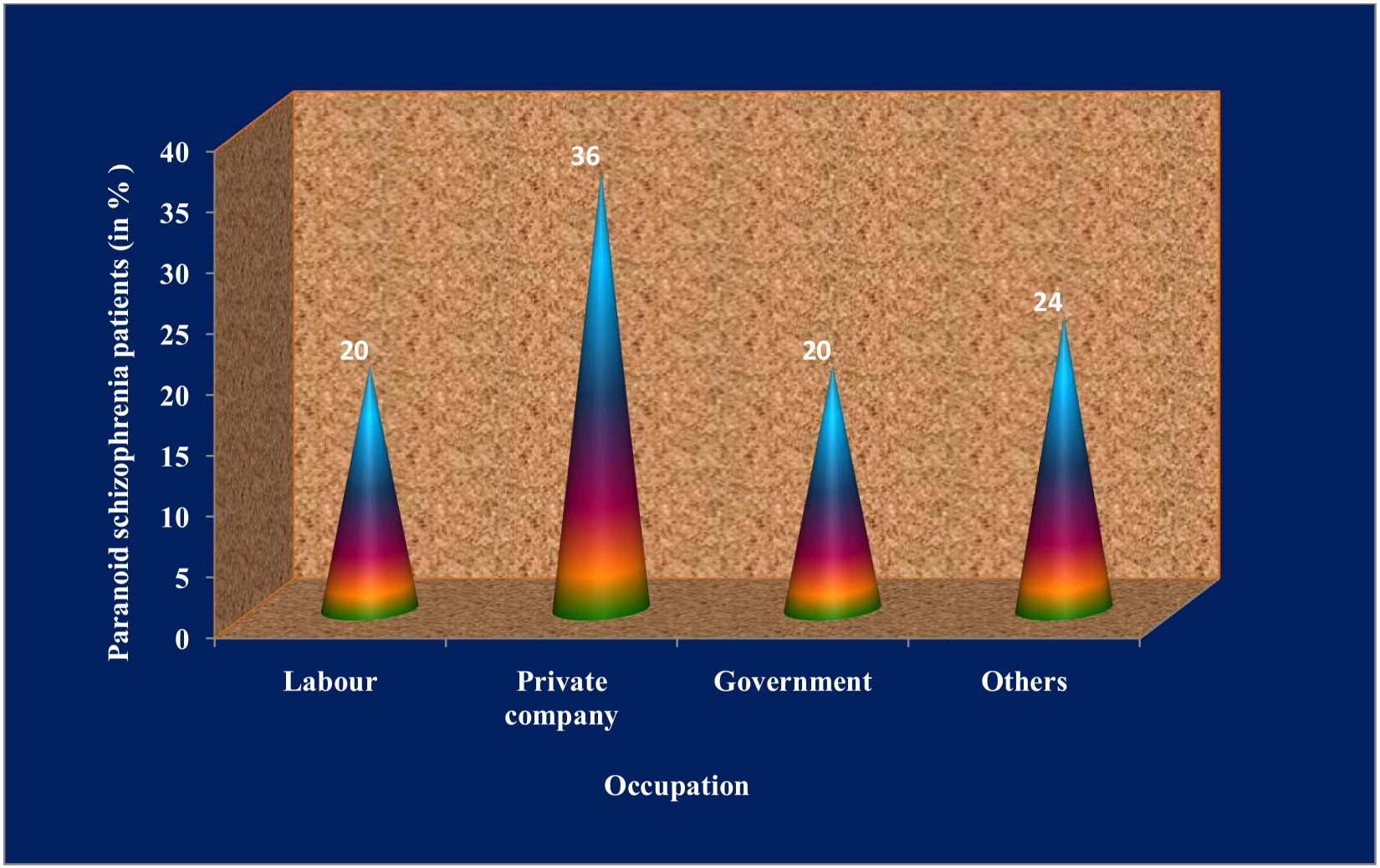

Fig.4.4. Occupation status of paranoid schizophrenia clients

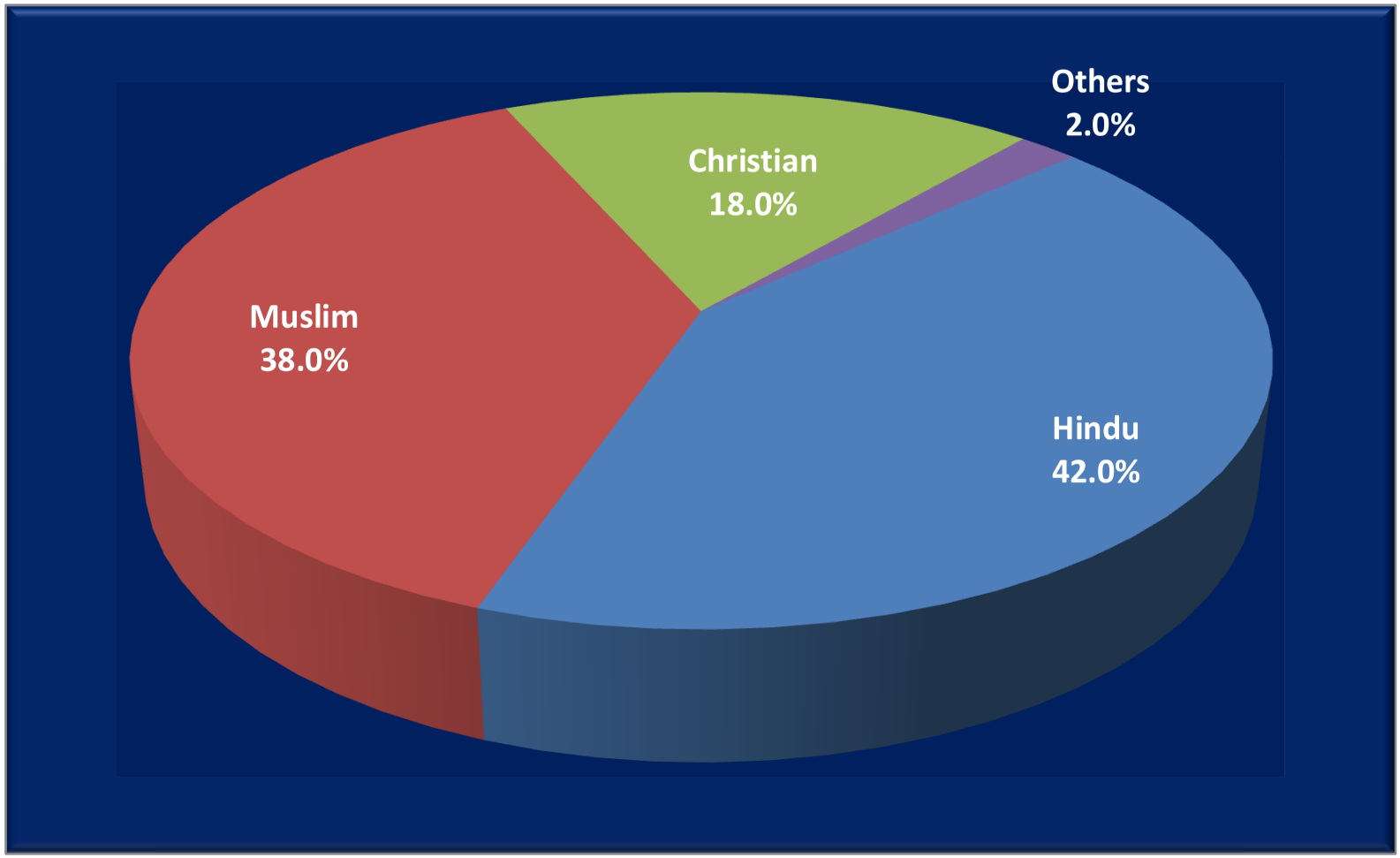

Fig.4.5. Religion wise distribution of paranoid schizophrenia clients

Fig.4.6. Residence wise distribution of paranoid schizophrenia clients

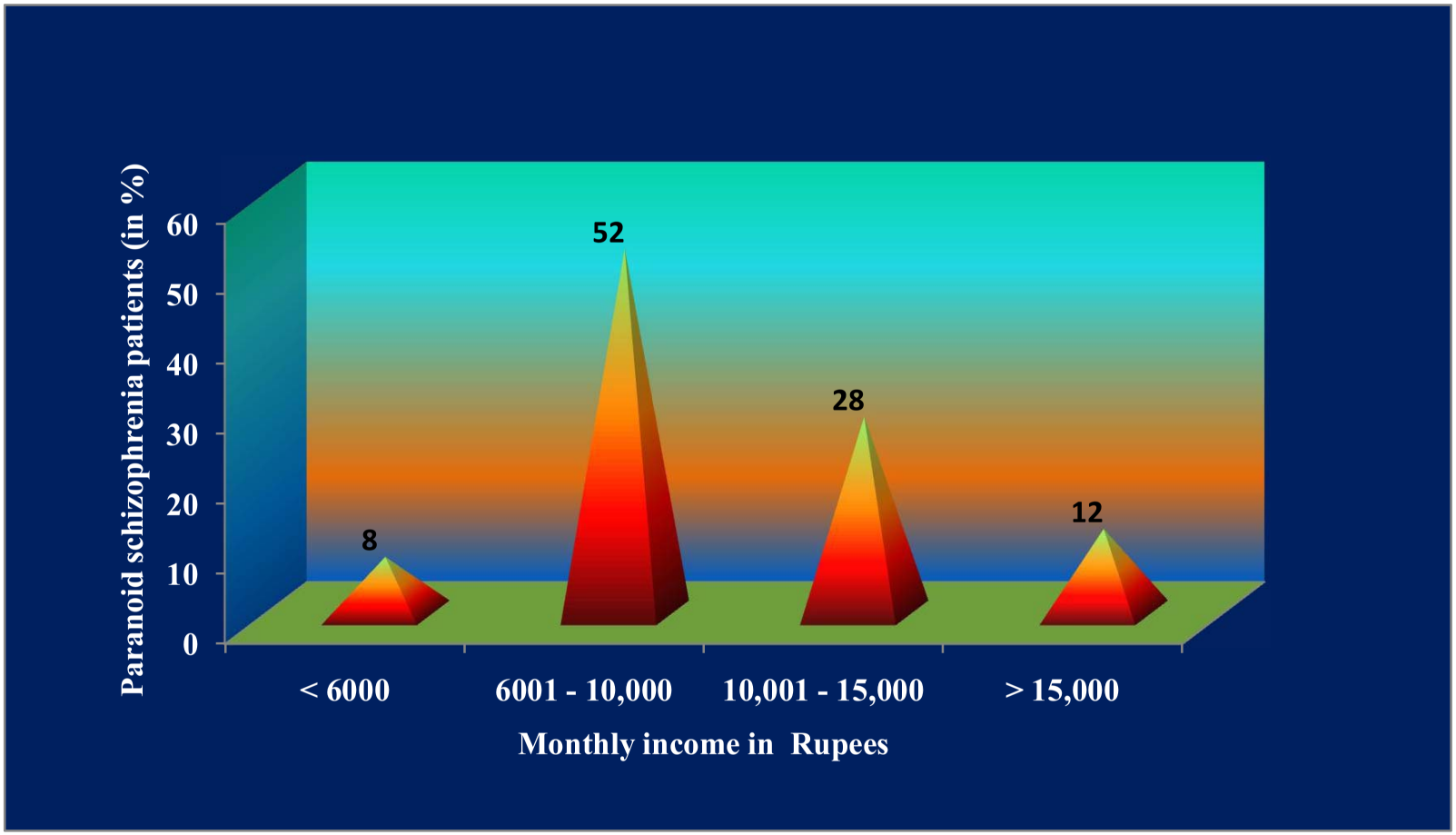

Fig.4.7. Family Monthly Income of paranoid schizophrenia clients

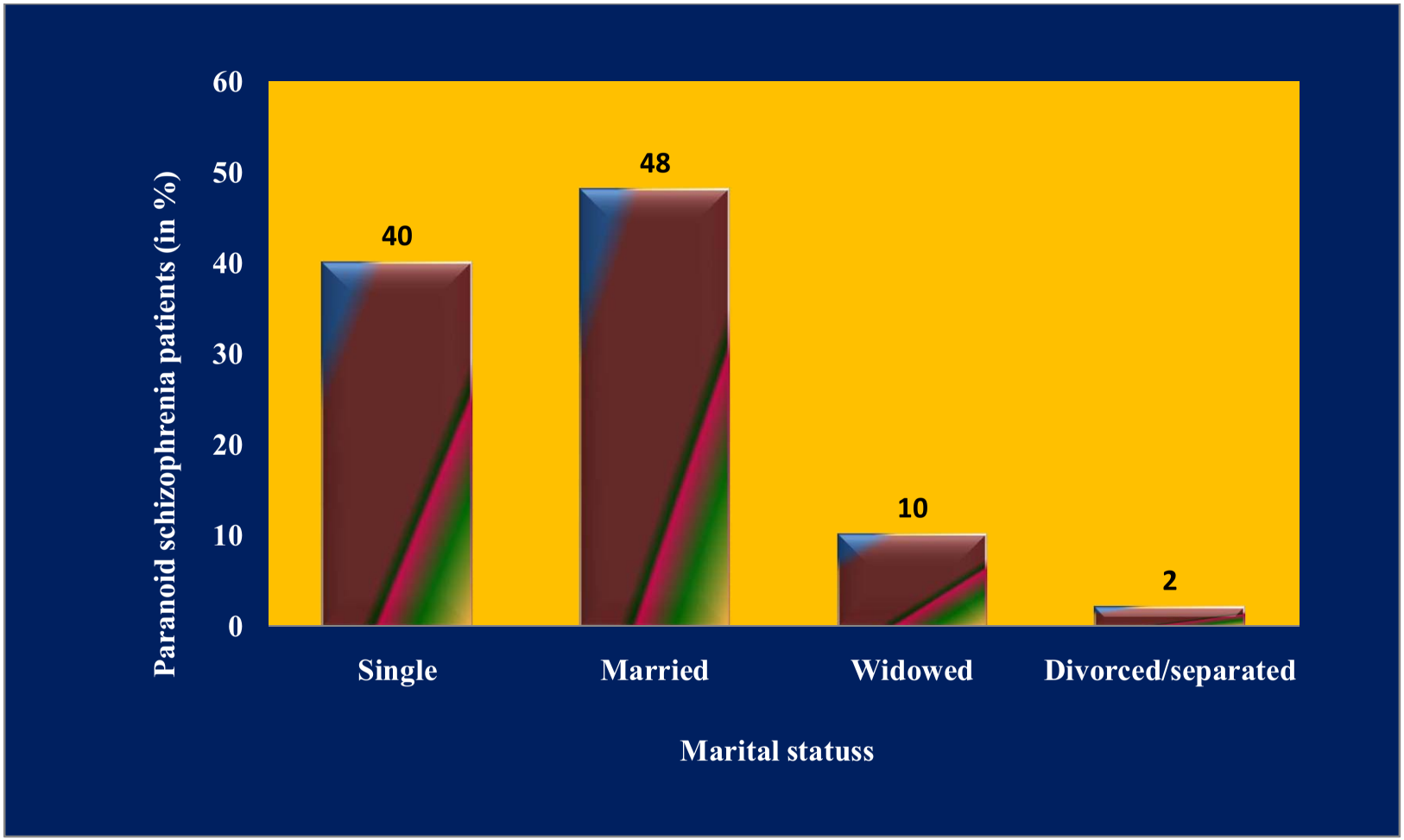

Fig.4.8. Marital status of paranoid schizophrenia clients

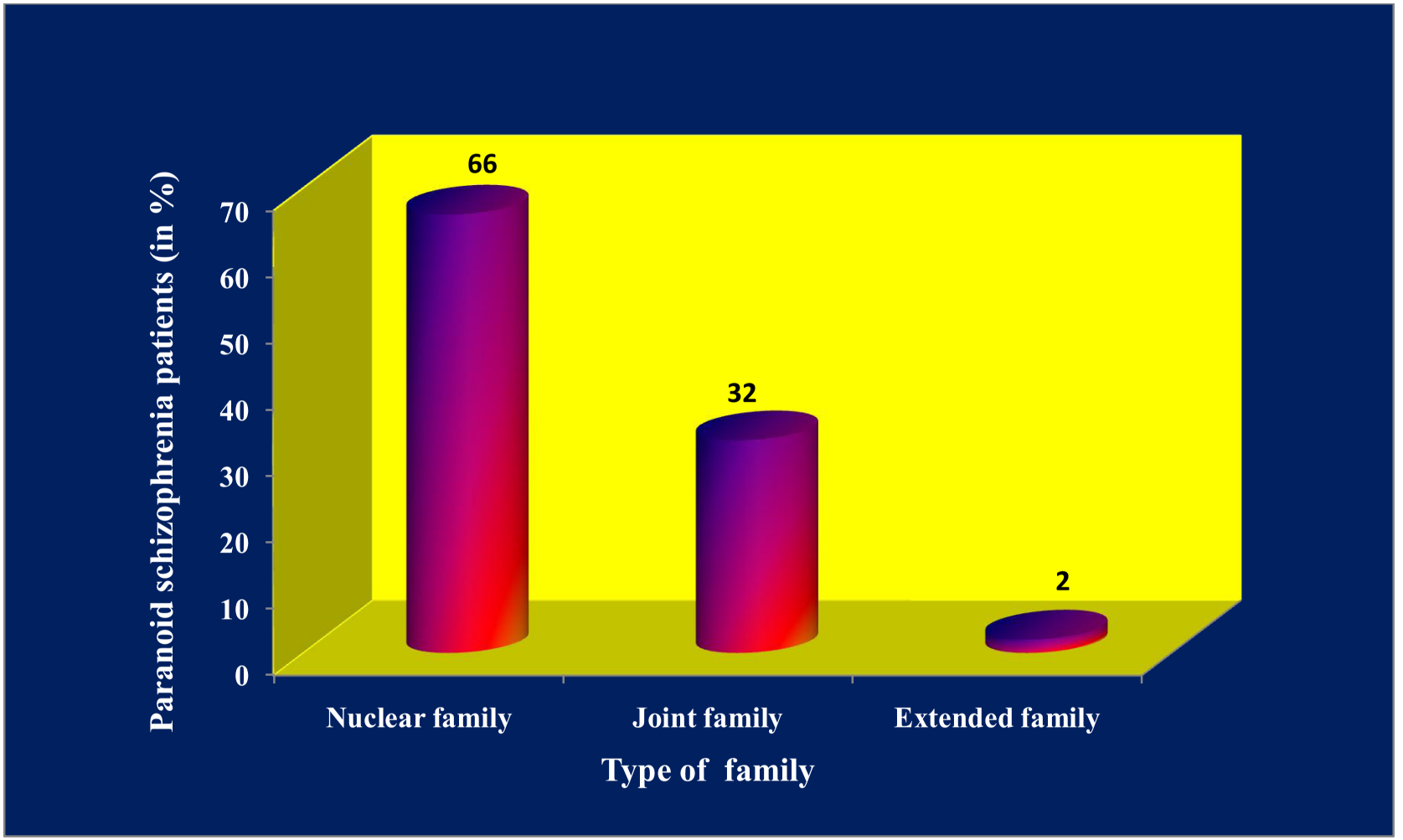

Fig.4.9. Family type of paranoid schizophrenia clients

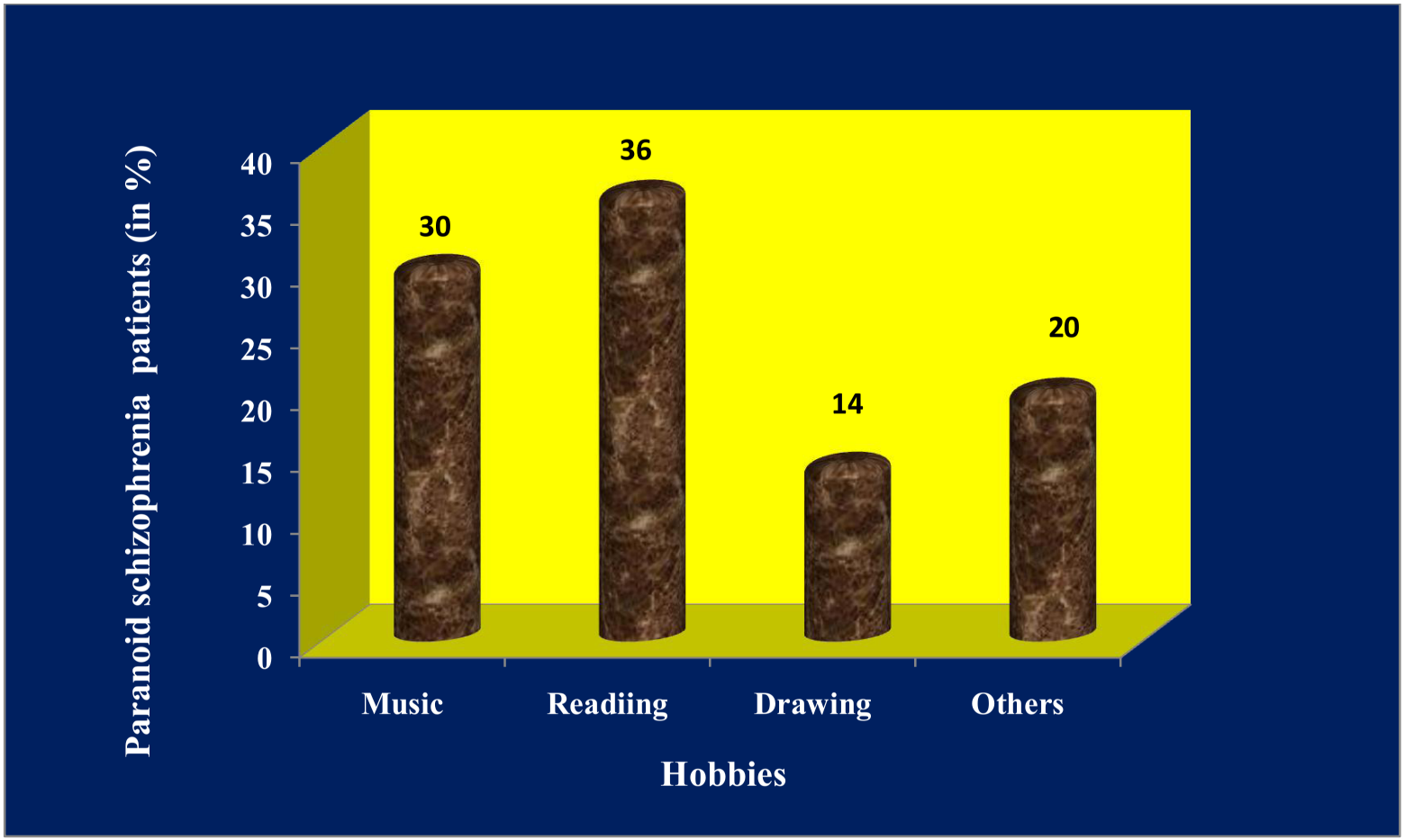

Fig.4.10. Hobby wise distribution of paranoid schizophrenia clients

Section II: Level of Psychiatric Symptoms before Art Therapy

Table 4.2: Pretest Brief Psychiatric Rating Scale (BPRS) score

SNO	Domains	Maximum score	Mean	Std Deviation	mean score in %
1	Somatic	7	4.90	1.36	70.0
2	Anxiety	7	5.12	1.26	73.1
3	Depression	7	5.18	1.35	74.0
4	Suicidality	7	4.98	1.30	71.1
5	Guilt	7	4.66	1.22	66.6
6	Hostility	7	5.04	1.23	72.0
7	Elated mood	7	4.96	1.35	70.9
8	Grandiosity	7	5.32	1.32	76.0
9	Suspiciousness	7	4.94	1.45	70.6
10	Hallucinations	7	4.82	1.21	68.9
11	Unusual thought content	7	4.94	1.36	70.6
12	Bizarre behaviour	7	5.12	1.24	73.1
13	Self neglect	7	4.78	1.34	68.3
14	Disorientation	7	4.84	1.20	69.1
15	Conceptual disorganization	7	4.76	1.24	68.0
16	Blunted effect	7	5.02	1.24	71.7
17	Emotional withdrawal	7	5.04	1.26	72.0
18	Motor retardation	7	4.30	1.20	61.4
19	Tension	7	4.74	1.43	67.7
20	Uncooperativeness	7	4.78	1.11	68.3
21	Excitement	7	4.72	1.25	67.4
22	Distractibility	7	4.74	1.44	67.7
23	Motor hyperactivity	7	4.58	1.37	65.4
24	Mannerism and posturing	7	4.40	1.36	62.9
	Overall	168	119.04	7.82	70.8

Above table depicts the pretest value of the psychiatric symptoms of paranoid schizophrenia clients were 76% have the grandiosity, 74% have depression symptom, 73% have anxiety and bizarre behavior, 72% have emotional withdrawal and hostility, and 71% have blunted effect and suicidality. About 70% have somatic and elated mood and suspiciousness.

Table 4.3: Pretest percentage of mean BPRS score

BPRS	Questions	Min –max score	Mean score	SD	mean score in %
Individual self report	14	14- 98	69.60	6.67	71.0
observed behaviour and speech	10	10 - 70	49.44	4.73	70.6
Total	24	7 - 168	119.04	7.82	70.8

The above table depicts that the pretest level of individual self report mean score was 71% and the observed behavior and speech mean score was 70.6%. On an average, clients have **70.8%** BPRS score.

Table 4.4: Pretest level of BPRS score

Level of BPRS	No. of clients	**%**
Mild	0	0.0
Moderate	38	76.0
Severe	12	24.0
Total	50	100

The table shows pretest level of BPRS score of psychiatric symptoms among paranoid schizophrenia clients before administering art therapy.

None of them have mild symptoms, 76% of them have moderate symptoms and 24% of them have severe symptoms.

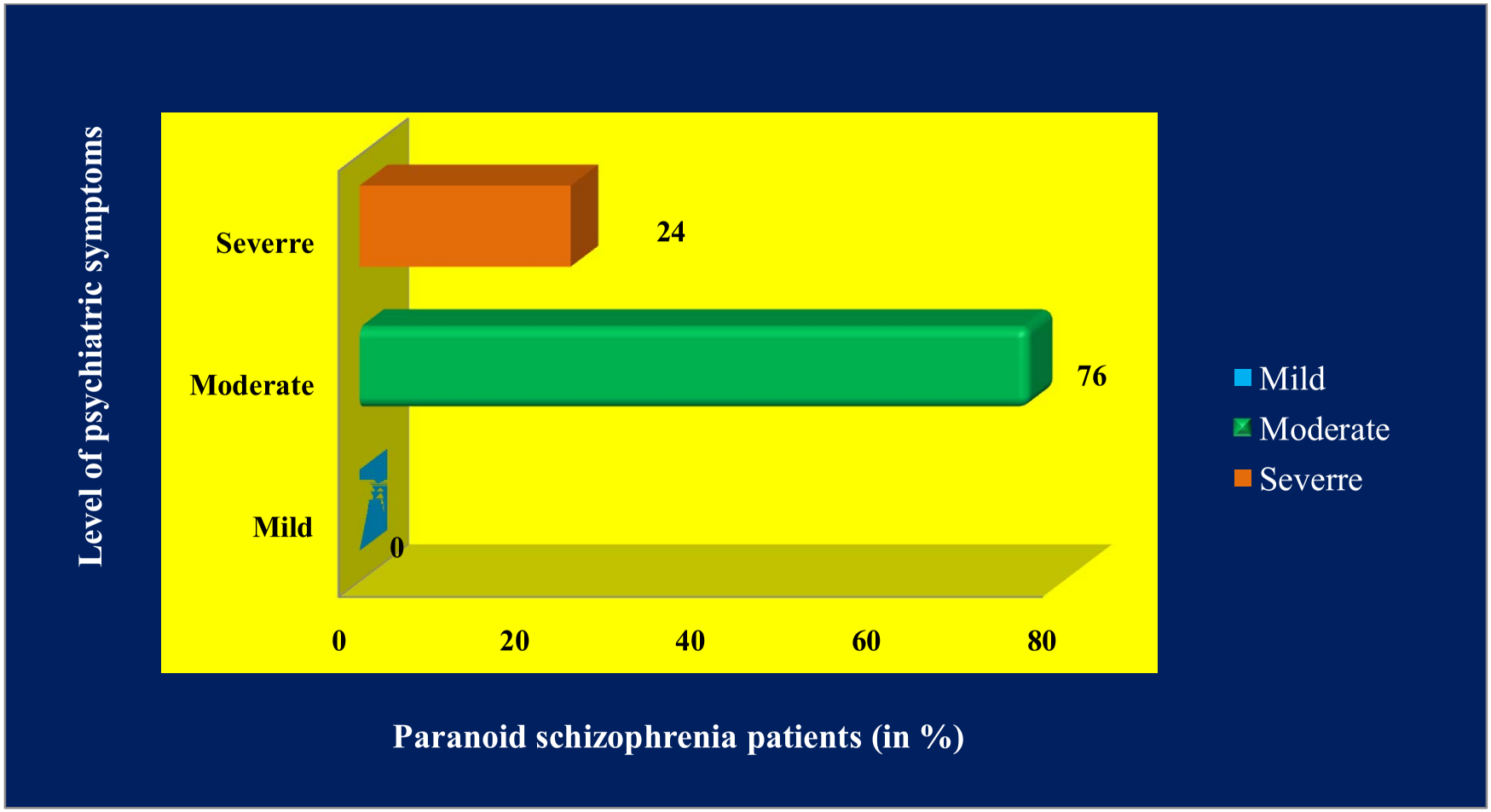

Fig.4.11 Pretest level of psychiatric symptoms of paranoid schizophrenia clients

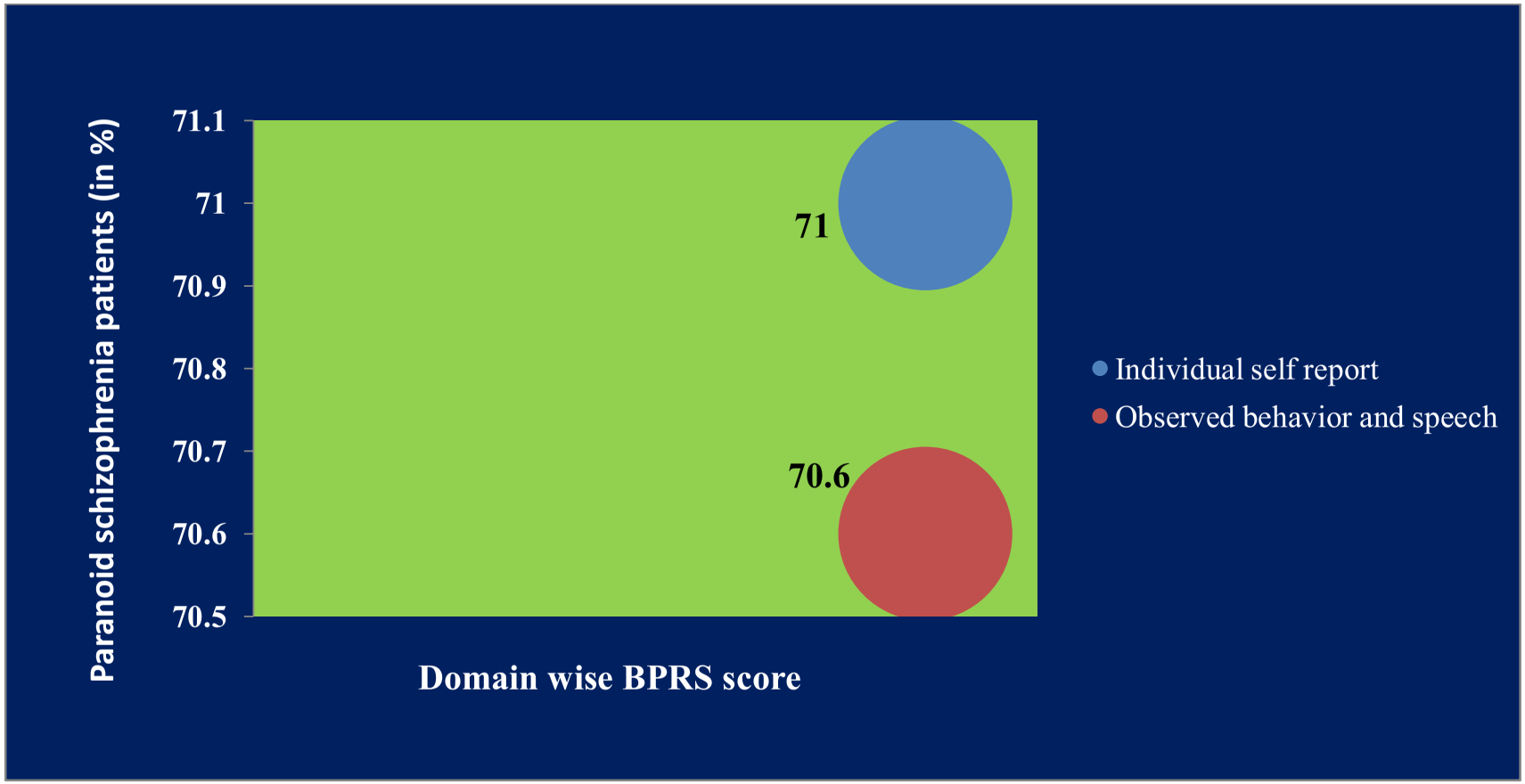

Fig.4.12. Domain wise distribution of pretest level of BPRS score

Section III: Level of psychiatric symptoms after art therapy

Table 4.5: Post test level of Basic Psychiatric Rating Scale score

SNO	Domains	Maximum score	Mean	Std Deviation	mean score in %
1	Somatic	7	2.88	.96	41.1
2	Anxiety	7	2.76	.94	39.4
3	Depression	7	2.70	.84	38.6
4	Suicidality	7	2.78	.79	39.7
5	Guilt	7	2.44	.76	34.9
6	Hostility	7	2.68	.74	38.3
7	Elated mood	7	2.66	.94	38.0
8	Grandiosity	7	3.04	1.23	43.4
9	Suspiciousness	7	3.02	1.20	43.1
10	Hallucinations	7	2.98	1.04	42.6
11	Unusual thought content	7	3.12	1.00	44.6
12	Bizarre behaviour	7	2.90	1.16	41.4
13	Self neglect	7	3.08	1.07	44.0
14	Disorientation	7	3.04	1.09	43.4
15	Conceptual disorganization	7	3.12	1.08	44.6
16	Blunted effect	7	3.30	1.16	47.1
17	Emotional withdrawal	7	3.20	1.05	45.7
18	Motor retardation	7	3.02	1.08	43.1
19	Tension	7	3.00	1.20	42.9
20	Uncooperativeness	7	3.14	1.18	44.9
21	Excitement	7	3.02	1.02	43.1
22	Distractibility	7	2.98	1.06	42.6
23	Motor hyperactivity	7	3.00	1.11	42.9
24	Mannerism and posturing	7	2.74	.96	39.1
	Overall	168	70.76	12.41	42.1

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The above table depicts the post test level of psychiatric symptoms of paranoid schizophrenia clients were 47% have blunted effect, 46% have emotional withdrawal, 45% have uncooperativeness, unusual thought content, self neglect, conceptual disorganization, 43% have grandiosity, suspiciousness, excitement, 42% have tension, distractibility, motor hyperactivity.

Table 4.6: Posttest percentage of mean score

BPRS	Questions	Min –max score	Mean score	SD	mean score in %
Individual self report	14	14- 98	40.08	8.08	40.8
Observed behaviour and speech	10	10 – 70	30.68	7.74	43.8
Total	24	7 – 168	70.76	12.41	42.1

The above table depicts that the posttest level of individual self report mean score was 41% and the observed behavior and speech mean score was 44%. On an average, clients have **42.1%** BPRS score.

Table 4.7: Posttest level of BPRS score

Level of BPRS	Frequency	%
Mild	36	72.0
Moderate	14	28.0
Severe	0	0.0
Total	50	100

Above table shows post test level of BPRS score of clients after administering ART therapy. 72.0% of them have the mild score, 28.0% of them have moderate BPRS score.

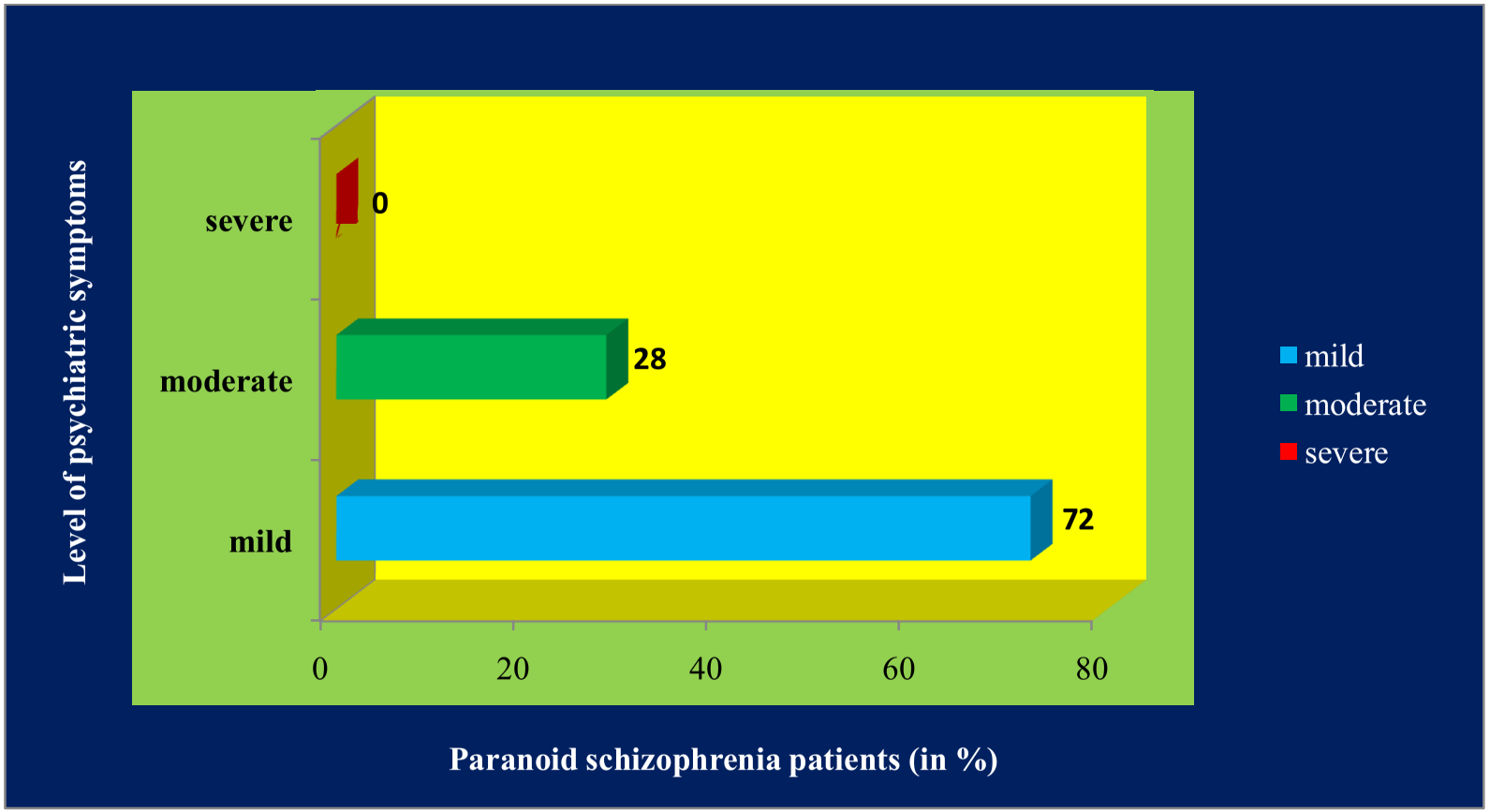

Fig.4.13 Post test level of psychiatric symptoms of paranoid schizophrenia patient

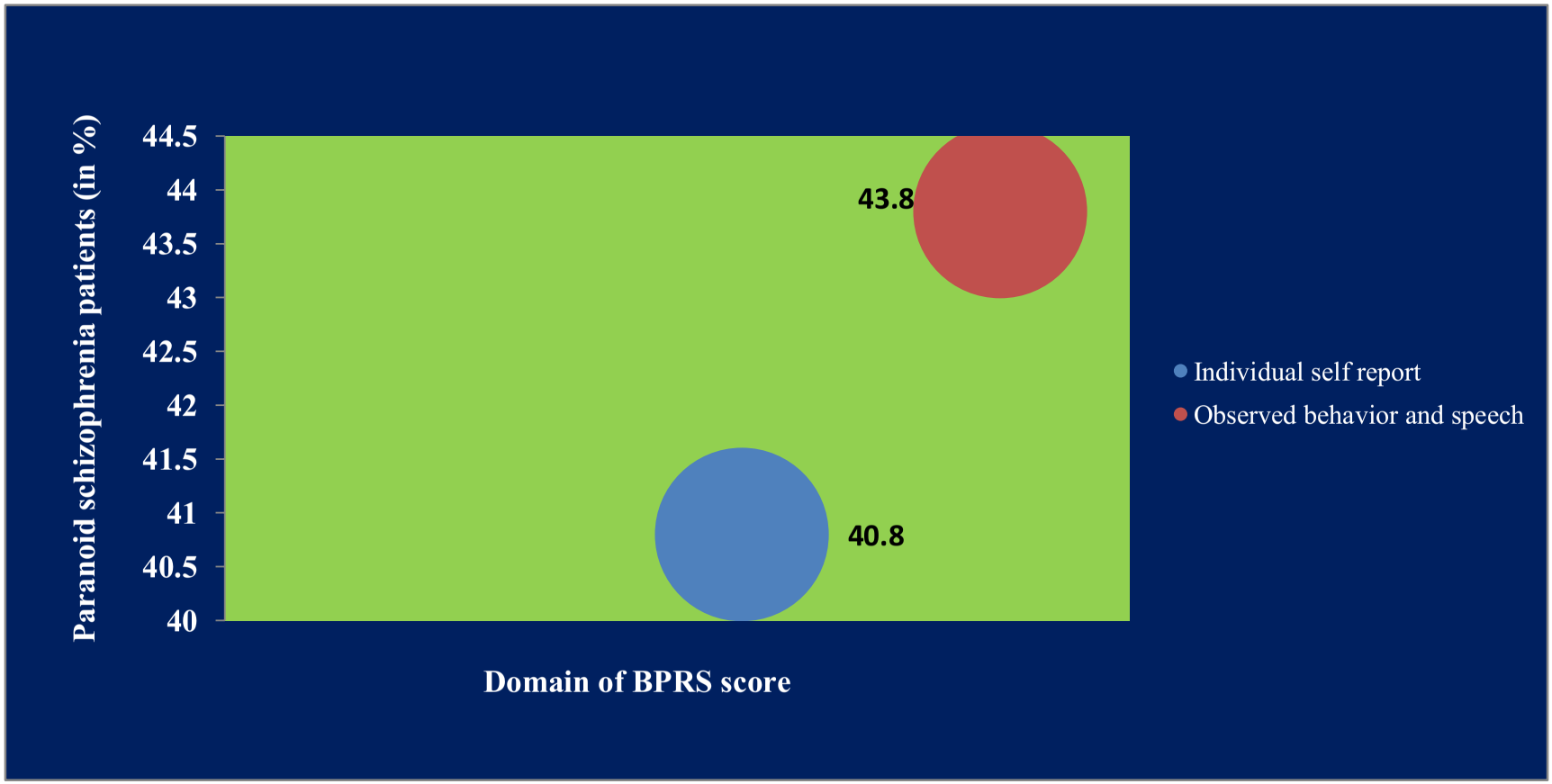

Fig. 4.14.Domain wise distribution of post test level of BPRS score

Table 4. 8: Comparison of BPRS mean score

SNO	Domains	Pre-test		Post-test		Student paired t-test
		mean	SD	mean	SD	
1	Somatic	4.90	1.36	2.88	.96	t=16.90 p=0.001***
2	Anxiety	5.12	1.26	2.76	.94	t=17.70 p=0.001***
3	Depression	5.18	1.35	2.70	.84	t=15.53 p=0.001***
4	Suicidality	4.98	1.30	2.78	.79	t=15.71 p=0.001***
5	Guilt	4.66	1.22	2.44	.76	t=15.45 p=0.001***
6	Hostility	5.04	1.23	2.68	.74	t=15.40 p=0.001***
7	Elated mood	4.96	1.35	2.66	.94	t=15.71 p=0.001***
8	Grandiosity	5.32	1.32	3.04	1.23	t=13.11 p=0.001***
9	Suspiciousness	4.94	1.45	3.02	1.20	t=11.38 p=0.001***
10	Hallucinations	4.82	1.21	2.98	1.04	t=12.54 p=0.001***
11	Unusual thought content	4.94	1.36	3.12	1.00	t=8.86 p=0.001***
12	Bizarre behaviour	5.12	1.24	2.90	1.16	t=10.74 p=0.001***
13	Self neglect	4.78	1.34	3.08	1.07	t=8.65 p=0.001***
14	Disorientation	4.84	1.20	3.04	1.09	t=16.90 p=0.001***
15	Conceptual disorganization	4.76	1.24	3.12	1.08	t=8.77 p=0.001***
16	Blunted effect	5.02	1.24	3.30	1.16	t=10.53 p=0.001***
17	Emotional withdrawal	5.04	1.26	3.20	1.05	t=6.75 p=0.001***
18	Motor retardation	4.30	1.20	3.02	1.08	t=11.54 p=0.001***
19	Tension	4.74	1.43	3.00	1.20	t=11.90 p=0.001***
20	Uncooperativeness	4.78	1.11	3.14	1.18	t=11.09 p=0.001***
21	Excitement	4.72	1.25	3.02	1.02	t=9.07 p=0.001***
22	Distractibility	4.74	1.44	2.98	1.06	t=6.90 p=0.001***
23	Motor hyperactivity	4.58	1.37	3.00	1.11	t=8.62 p=0.001***
24	Mannerism and posturing	4.40	1.36	2.74	.96	t=9.35 p=0.001***

*Significant at $P \leq 0.05$, ** highly significant at $P \leq 0.01$, *** very high significant at $P \leq 0.001$

Table 4.9**:** Comparison of overall BPRS score

	Frequency	**Mean ± SD**	**Mean Difference**	**Student's paired t-test**
Pretest	50	119.04±7.82	48.28	t=30.42 P=0.001***
posttest	50	70.76±2.37		

* Significant at $P \leq 0.05$, ** Highly significant at $P \leq 0.01$, *** Very high significant at $P \leq 0.001$

Table no 4 .9 shows the comparison of overall BPRS score between pre-test and post-test.

In pretest, clients have 119.04 score whereas in post-test they have 70.76 score, so the difference is 48.28. This difference between pretest and posttest is large and it is statistically significant**. *Difference between pre-test and post-test score was analyzed using paired t-test.***

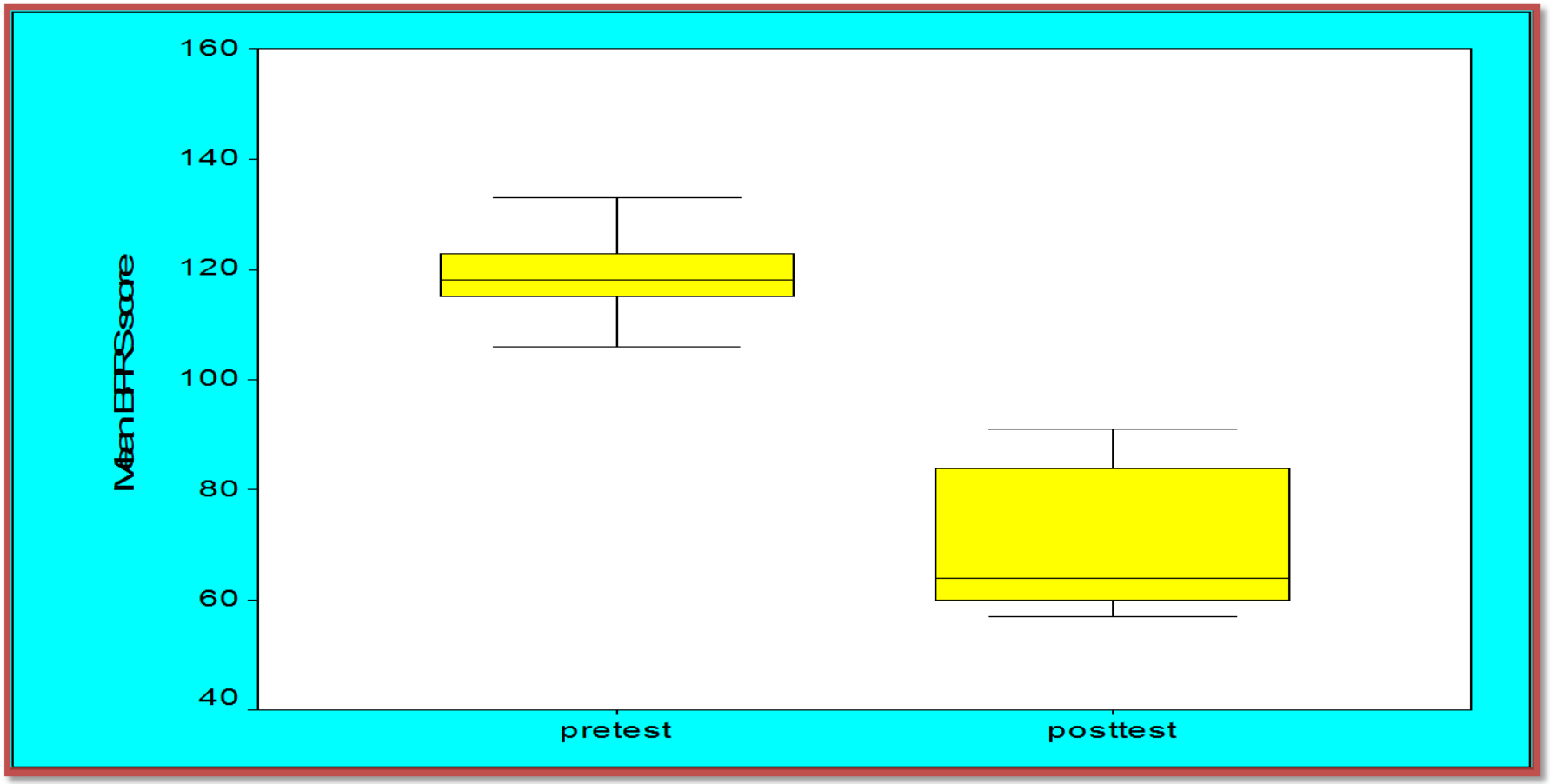

Fig 4.15: Box-plot shows the comparison of pre-test and post-test BPRS score among paranoid schizophrenia clients.

Table 4.10: Comparison of pretest and posttest score

Level of BPRS	Pretest		Posttest		Chi square test
	Frequency	%	Frequency	%	
Mild	0	0.0	36	72.0	$\chi 2=59.07$ P=0.001***
Moderate	38	76.0	14	28.0	
Severe	12	24.0	0	0.0	
Total	50	100	50	100	

* Significant at $P \leq 0.05$, ** highly significant at $P \leq 0.01$, *** very high significant at $P \leq 0.001$

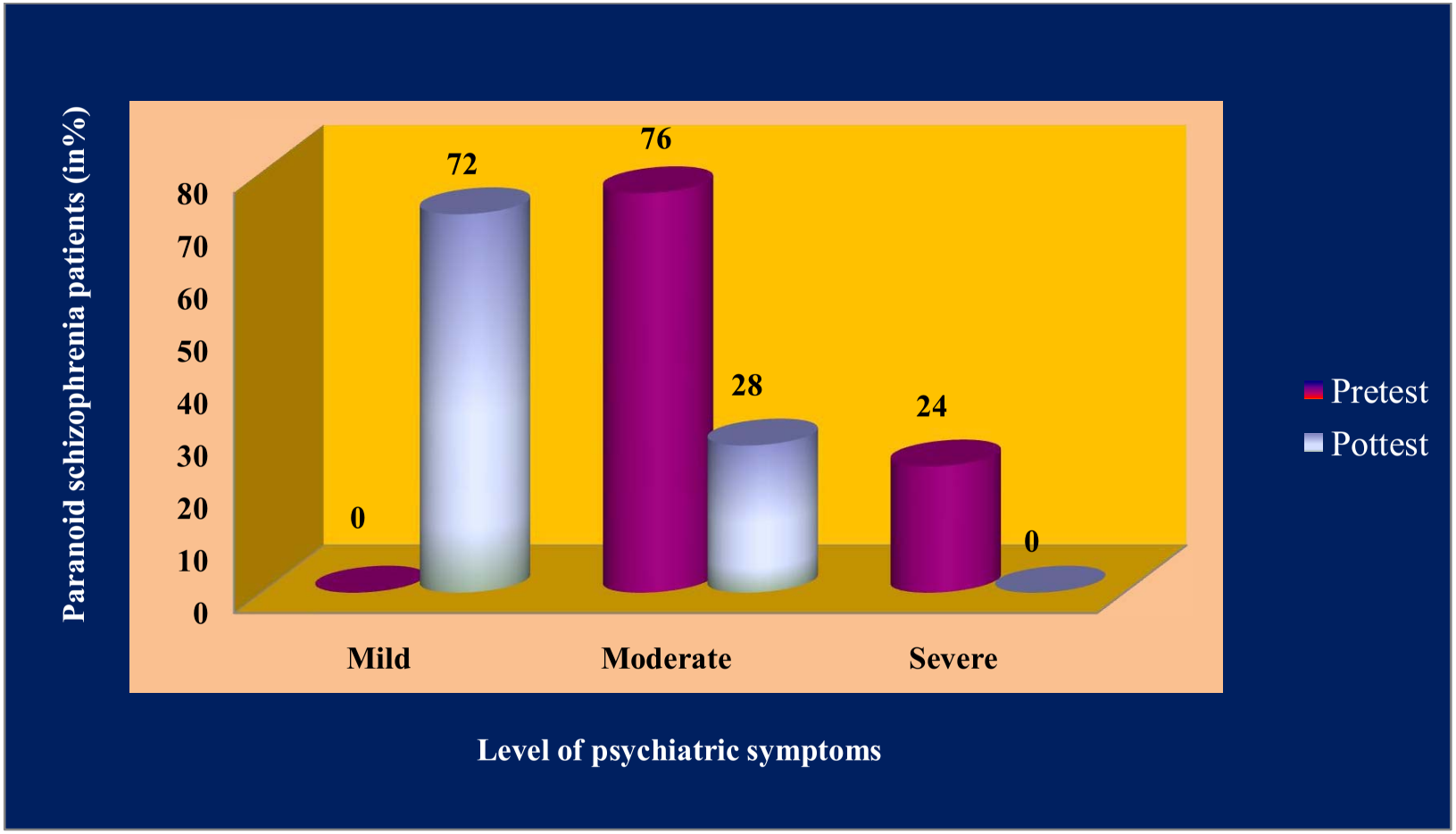

Fig.4.16. Comparison of pre –test and post –test percentage of psychiatric symptoms

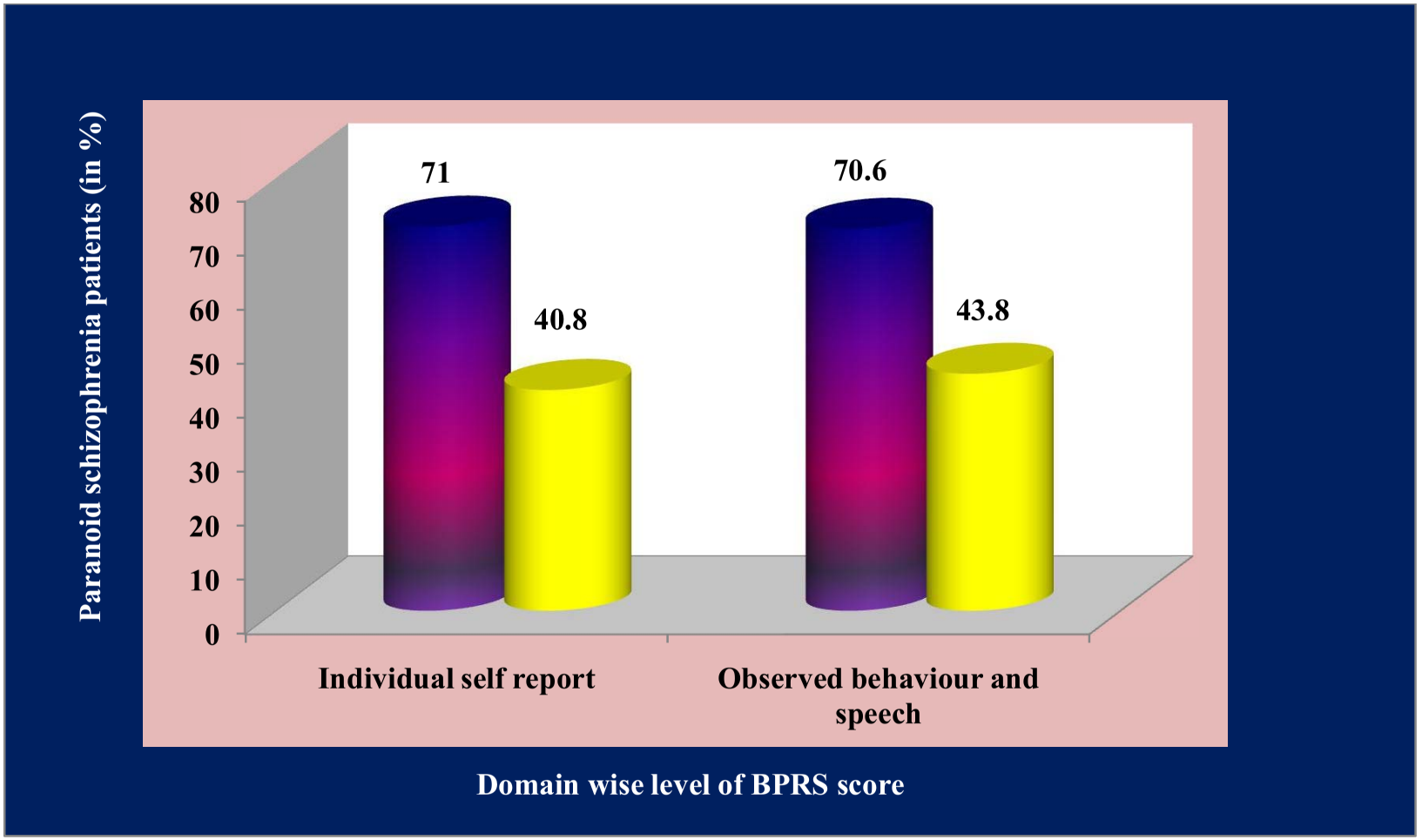

Fig.4.17. Domain wise comparison of level of psychiatric symptoms of paranoid schizophrenia clients

Table 4.11 Shows each question wise BPRS reduction score.

Sno	Questions	Pretest	Posttest	BPRS reduction score in %
1	Somatic	70.0	41.1	28.9
2	Anxiety	73.1	39.4	33.7
3	Depression	74.0	38.6	35.4
4	Suicidality	71.1	39.7	31.4
5	Guilt	66.6	34.9	31.7
6	Hostility	72.0	38.3	33.7
7	Elated mood	70.9	38.0	32.9
8	Grandiosity	76.0	43.4	32.6
9	Suspiciousness	70.6	43.1	27.5
10	Hallucinations	68.9	42.6	26.3
11	Unusual thought content	70.6	44.6	26.0
12	Bizarre behaviour	73.1	41.4	31.7
13	Self neglect	68.3	44.0	24.3
14	Disorientation	69.1	43.4	25.7
15	Conceptual disorganization	68.0	44.6	23.4
16	Blunted effect	71.7	47.1	24.6
17	Emotional withdrawal	72.0	45.7	26.3
18	Motor retardation	61.4	43.1	18.3
19	Tension	67.7	42.9	24.8
20	Uncooperativeness	68.3	44.9	23.4
21	Excitement	67.4	43.1	24.3
22	Distractibility	67.7	42.6	25.1
23	Motor hyperactivity	65.4	42.9	22.5
24	Mannerism and posturing	62.9	39.1	23.8
	Overall	69.5	42.1	27.4

The above table shows the reduction score of BPRS scale for psychiatric symptoms of paranoid schizophrenia were 35% reduction in depression 34% reduction in anxiety and hostility 33% reduction in elated mood, grandiosity, 32 % in suicidality, guilt, and bizarre behavior but there was only 28% reduction in suspiciousness.

Table 4.12: Mean difference of BPRS reduction score

BPRS	**Pretest**		**Posttest**		**Difference**	**Student independent t-test**
	Mean	**SD**	**Mean**	**SD**		
Individual self report	69.60	6.67	40.08	8.08	29.52	t=35.87 p=0.001***
Observed behaviour and speech	49.44	4.73	30.68	7.74	18.76	t=16.45 p=0.001***
Total	119.04	7.82	70.76	12.41	48.28	t=30.24 p=0.001***

Considering , **individual self report** aspects , In pretest , clients have 69.60 score and in posttest they are having 40.08 score , so the difference is 29.52.

Considering, **observed behaviour and speech** aspects, in pretest, clients have 49.44 score and in posttest they are having 30.68 score, so the difference is 18.76. This difference between pretest and posttest is large and it is statistically significant. ***Differences between pretest and posttest score was analysed using paired t-test.***

Considering **overall** aspects, in pretest the paranoid schizophrenia clients have the psychiatric symptoms level of 119.04 and in posttest they have 70.76, so the difference is 48.28. This difference between pretest and posttest is large and it is statistically significant. ***Differences between pretest and posttest score was analysed using paired t-test.***

Table 4.13: Percentage of BPRS reduction score

BPRS	Pretest % of mean score	Posttest % of mean score	Difference %
Individual self report	71.0	40.8	30.2
Observed behaviour and speech	70.6	43.8	26.8
Total	70.8	42.1	28.7

The above table depicts that difference between the individual self report results were 30% and the observed behavior and speech result was 27%. On average clients have 70.8% BPRS score.

Section IV: Effectiveness of art therapy

Table 4.14: Effectiveness of Art Therapy

	Max score	Mean BPRS score	Mean Difference in BPRS reduction score with 95% Confidence interval	Percentage of BPRS reduction score with 95% Confidence interval
Pretest	168	119.04	48.28(45.07 – 51.49)	28.7(26.8–30.6)
Posttest	168	70.76		

The table shows the comparison of overall BPRS score between pre-test and post-test levels of psychiatric symptoms of paranoid schizophrenia were **reduced to** 28.7% after implementing art therapy. Differences between pre-test and post-test score were analysed using percentage with 95% CI and mean difference with 95% CI.

Table 4.15: Association between level of BPRS reduction score and clients demographic variables.

Demographic variables			Level of BPRS reduction score				Total	Chi square test
			Below average (≤48.28)		Above average (> 48.28)			
			frequency	%	frequency	%		
1.	Age	21 -30 years	3	75.0	1	25.0	4	**χ2=9.28 p=0.05* DF=3**
		31 -40 years	18	64.3	10	35.7	28	
		41 -50 years	4	25.0	12	75.0	16	
		51 -60 years	0	0.0	2	100.0	2	
2.	Sex	Male	8	47.1	9	52.9	17	χ2=0.09 p=0.75 DF=1
		Female	17	51.5	16	48.5	33	
3.	Education	No formal education	7	87.5	1	15.0	8	**χ2=10.97 p=0.01** DF=3**
		Schooling	11	64.7	6	35.3	17	
		College grade	6	30.0	14	70.0	20	
		Above college grade	1	20.0	4	80.0	5	
4.	Occupation	Labor	6	60.0	4	40.0	10	χ2=3.55 p=0.31 DF=3
		Private company	8	44.4	10	55.6	18	
		Government	3	30.0	7	70.0	10	
		Others	8	66.7	4	33.3	12	
5.	Monthly Income	< Rs.6000	3	75.0	1	25.0	4	**χ2=8.69 p=0.05* DF=3**
		Rs.6001 - Rs.10,000	17	65.4	9	34.6	26	
		Rs.10,001 - Rs.15,000	4	28.6	10	71.4	14	
		> Rs.15,000	1	16.7	5	83.3	6	
6.	Religion	Hindu	12	57.1	9	42.9	21	χ2=2.01 p=0.57 DF=3
		Muslim	8	42.1	11	57.9	19	
		Christian	4	44.4	5	55.6	9	
		Others	1	100.0			1	
7.	Residency	Urban	18	45.0	22	55.0	40	χ2=2.00 p=0.15 DF=1
		Rural	7	70.0	3	30.0	10	
8.	Marital status	Single	11	55.0	9	45.0	20	χ2=1.56 p=0.66 DF=3
		Married	11	45.8	13	54.2	24	
		Widowed	3	60.0	2	40.0	5	
		Divorced/separated			1	100.0	1	
9.	Type of Family	Nuclear family	16	48.5	17	51.5	33	χ2=1.03 p=0.59 DF=2
		Joint family	8	50.0	8	50.0	16	
		Extended family	1	100.0			1	
10.	Hobby	Music	5	33.3	10	66.7	15	χ2=3.09 p=0.37 DF=3
		Reading	11	61.1	7	38.9	18	
		Drawing	3	42.9	4	57.1	7	
		Others	6	60.0	4	40.0	10	

The above table shows the association between the level of BPRS reduction score with the socio demographic variables. age group of above 31 years to 40 years, graduates and the clients getting more monthly income are reduced more psychiatric symptoms (BPRS score). Using chi square test those groups were identified that they were statistically significance groups.(p=0.005) for age and monthly income group and (p=0.01) significance for education level groups with psychiatric symptoms.

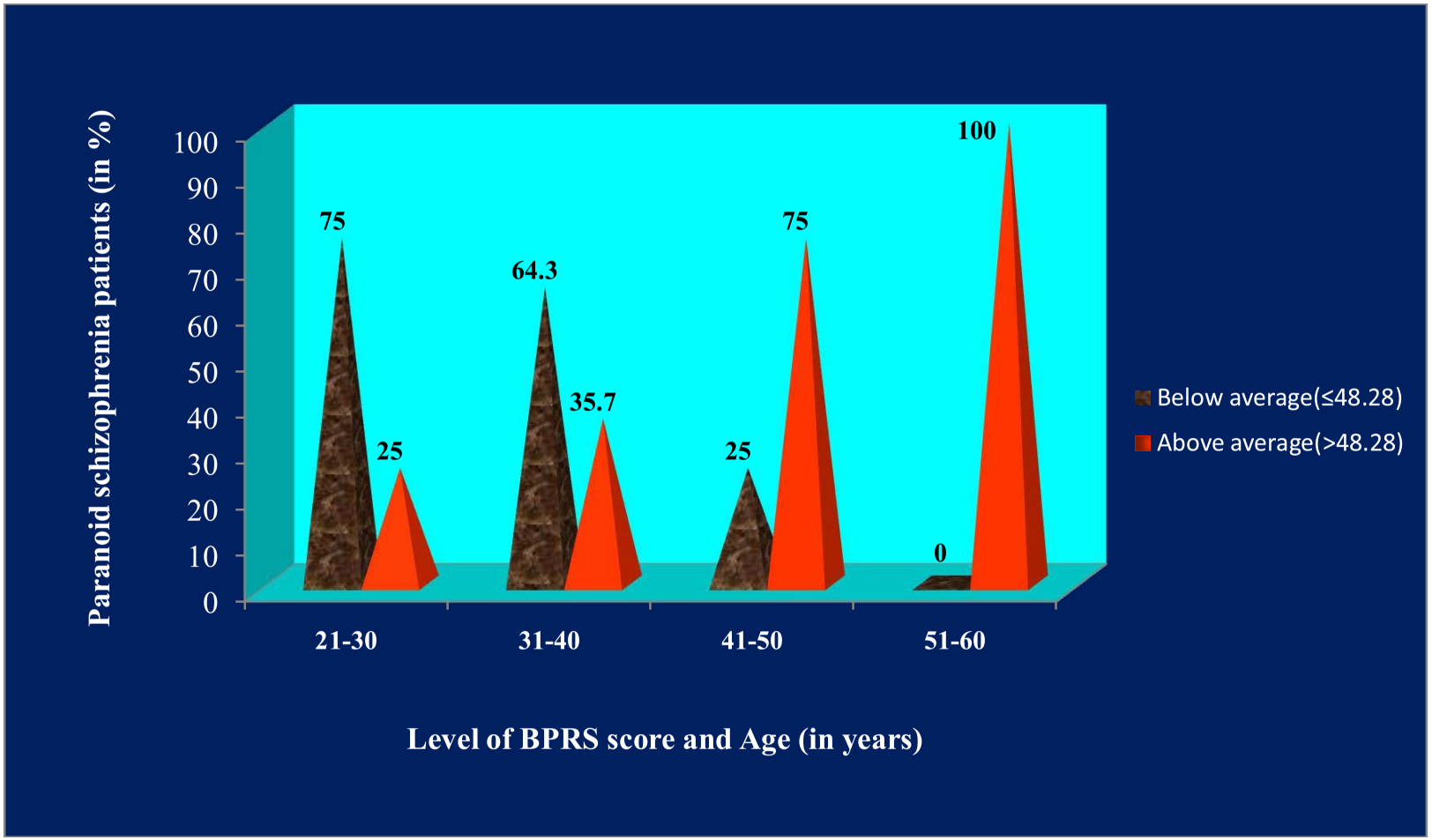

Fig.4.18. Association between the BPRS reduction score and age of paranoid schizophrenia clients

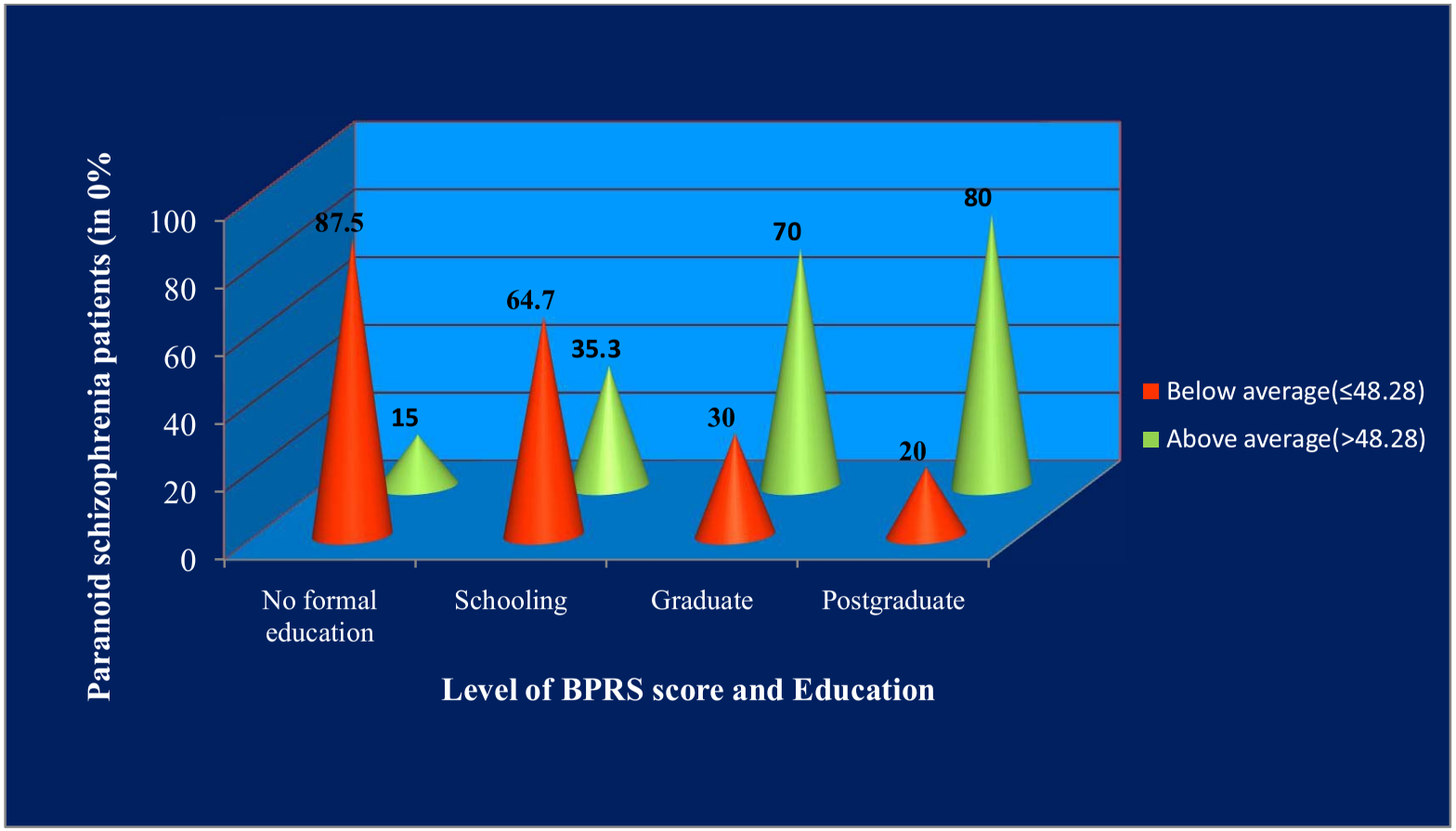

Fig.4.19. Association between level of BPRS reduction score and education status

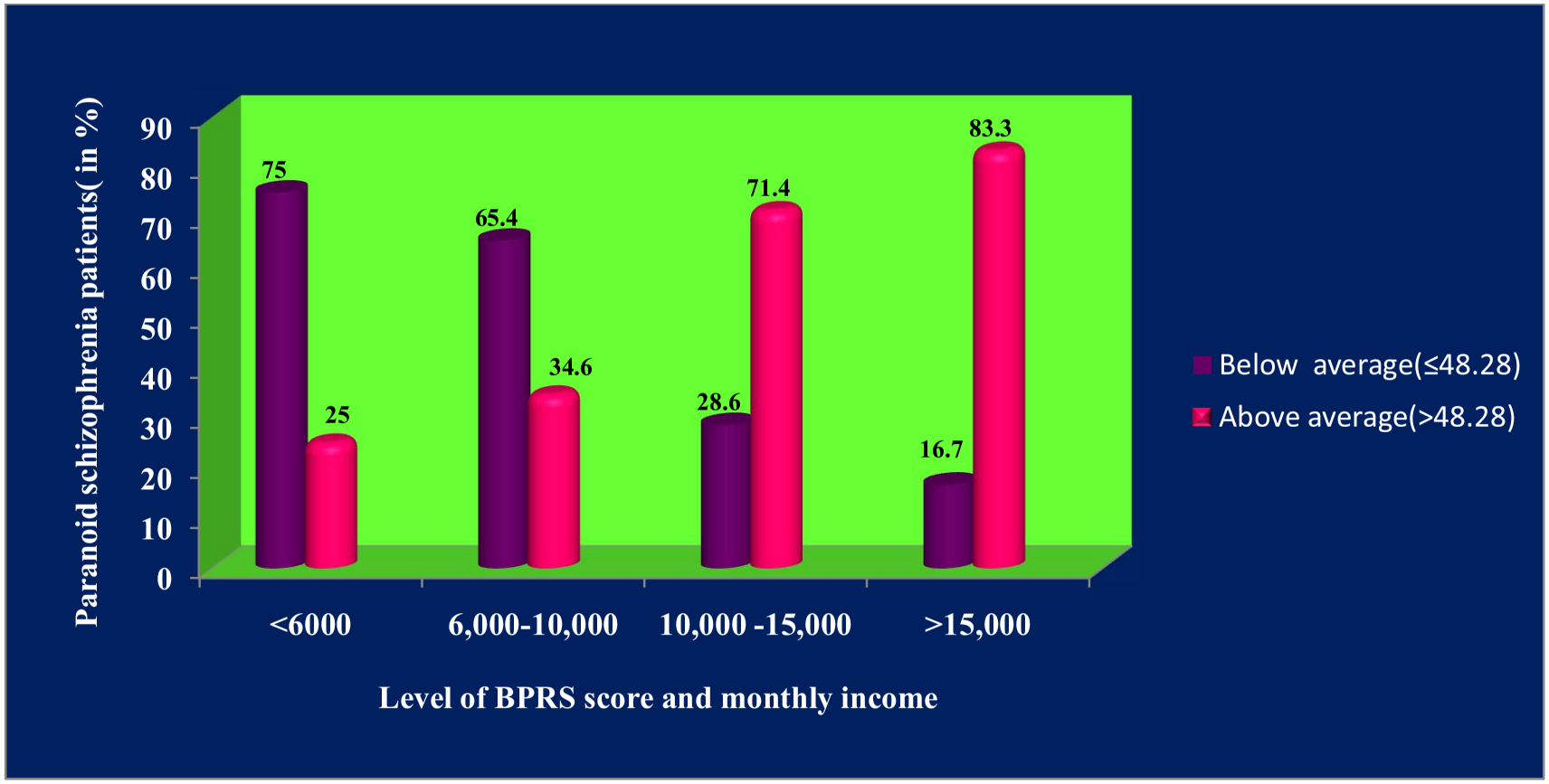

Fig.4.20. Association between level of BPRS reduction score and the family monthly income of paranoid schizophrenia clients.

CHAPTER V

SUMMARY OF THE RESULTS

MAJOR FINDINGS OF THE STUDY

5.1. Findings of the socio-demographic data:

- Among the study participants 56% of the clients were in the age group of 31 -40 years.
- Most of them were female (66%).
- Most of them 80% were living in urban area.
- Thirty six percentage of them were working in private companies.
- Half of the study population getting Rs.6000 – 10,000/- salary per month.
- Majority of the participants were Hindu (42%).
- And 48% of them were married.
- About 66% of them were living in nuclear family type.
- Reading books is the main hobby of the study population (36%).

5.2. Findings on pre test level of psychiatric symptoms:

The pretest value of the psychiatric symptoms of paranoid schizophrenia clients were 76% have the grandiosity, 74% have depression symptom, 73% have anxiety and bizarre behavior, 72% have emotional withdrawal and hostility, and 71% have blunted effect and suicidality. About 70% have somatic and elated mood and suspiciousness

The pretest level of BPRS scores of psychiatric symptoms among paranoid schizophrenia clients before administering art therapy. The pretest level of individual self report mean score was 71% and the observed behavior and speech mean score was 70.6%. On an average, clients have **70.8%** BPRS score.

None of them have mild symptoms, 76% of them have moderate symptoms and 24% of them have severe symptoms.

5.3. Findings on the post test level of psychiatric symptoms among paranoid schizophrenia patient after art therapy:

The post test level of psychiatric symptoms of paranoid schizophrenia clients were 47% have blunted effect, 46% have emotional withdrawal, 45% have uncooperativeness, unusual thought content, self neglect, conceptual disorganization, 43% have grandiosity, suspiciousness, excitement, 42% have tension, distractibility, motor hyperactivity.

The posttest level of individual self report mean score was 41% and the observed behavior and speech mean score was 44%. On an average, clients have **42.1%** BPRS score

The post test level of BPRS scores of clients after administering art therapy. 72.0% of them have of the mild score, 28.0% of them have moderate BPRS score.

5.4. Findings on effectiveness of art therapy:

The reduction score of BPRS scale for psychiatric symptoms of paranoid schizophrenia were 35% reduction in depression 34% reduction in anxiety and hostility 33% reduction in elated mood, grandiosity, 32 % in suicidality, guilt, and bizarre behavior but there was only 28% reduction in suspiciousness.

The comparison of overall BPRS score between pre-test and post-test levels of psychiatric symptoms of paranoid schizophrenia were **reduced to** 28.7% after implementing art therapy. Differences between pre-test and post-test score were analysed using percentage with 95% CI and mean difference with 95% CI.

Considering , **individual self report** aspects , in pretest , clients have 69.60 score and in posttest they have 40.08 score , so the difference is 29.52. This difference between pretest and posttest is large and it is statistically

significant. *Differences between pretest and posttest score was analysed using paired t-test.*

Considering, **observed behaviour and speech** aspects, in pretest, clients have 49.44 score and in posttest they have 30.68 score, so the difference is 18.76. This difference between pretest and posttest is large and it is statistically significant. *Differences between pretest and posttest score was analysed using paired t-test.*

Considering, **overall** aspects, in pretest, clients have 119.04 score and in posttest they have 70.76 score, so the difference is 48.28. This difference between pretest and posttest is large and it is statistically significant. *Differences between pretest and posttest score was analysed using paired t-test.*

5.5. Findings on the association between the demographic variables and the level of psychiatric symptoms among paranoid schizophrenia clients:

The association between the level of BPRS reduction score with the socio demographic variables. age group of above 31 years to 40 years, graduates and the clients getting more monthly income are reduced more psychiatric symptoms (BPRS score). Using chi square test those groups were identified that they were statistically significance groups.($p=0.005$) for age and monthly income group and ($p=0.01$) significance for education level groups with psychiatric symptoms.

CHAPTER VI

DISCUSSION

This chapter deals with the detailed discussion on the findings of the study obtained from the statistical analysis.

Objective I: To identify the socio demographic variables of the paranoid schizophrenia clients admitted in Institute of Mental Health.

Among the 51 paranoid schizophrenia clients studied 56% were in the age group of 31 -40 years and most of them were female (66%).

The one-year prevalence of early-onset schizophrenia was 0.35%, of late –onset schizophrenia 0.14%, and of very late onset schizophrenia like psychosis is 0.05%. Variation of onset criterion affected the proportion of early onset versus late onset schizophrenia clients **stronger in women than in men**. Women outnumbered men markedly in the prevalence estimates for most diagnostic subgroups, including early onset schizophrenia. **(Meesters, Paul D.MD., DeHaan, et al 2012)**

This study findings are not consistent with the findings of **Zhang, Xiang Yang et.al(2009)** prevalence was 33.7% with rates of 39.2% (138/352) in males and 22.4% (38/170) in females ($\chi 2=14.6$, df=1, $p<0.0001$; adjust odds ratio 2.06; CI, 1.32-3.16). The score in clients with psychiatric symptoms was **lower in females than males** (5.3±3.9 vs 6.7±3.7, t=2.52, $p<0.01$) after adjustment for the significant covariates.

The findings of **WU, ERIC.Q, SHI, LIZHENG et,al (2006)** the negative symptoms on the PANSS in both genders, and with age, PANSS total and positive symptoms in men, not women. This study finding suggested that this study is limited by cross-sectional designs, the magnitude **of these gender-specific differences is substantial** and deservers further prospective study.

This study consistent with these findings is the literature of life events with stressful effect in gender variation for initiation and progress of the schizophrenia. The results of the study showed the presence of correlation between some of the studied life events, assessed as stressful. The analysis of the data revealed that **both sex and age** are influencing the assessment of the significance of the life events and "increases" their importance **both for women and men.**

Objective II: To assess the psychiatric symptoms among paranoid schizophrenia clients before art therapy.

In this study the investigator found the pretest value of the psychiatric symptoms of paranoid schizophrenia clients were 76% have the grandiosity, 74% have depression symptom, 73% have anxiety and bizarre behavior, 72% have emotional withdrawal and hostility, and 71% have blunted effect and suicidality. About 70% have somatic and elated mood and suspiciousness.

In this study the investigator found the pretest level of BPRS score of psychiatric symptoms among paranoid schizophrenia clients before administering art therapy were none them have mild symptoms, but 76% of them have moderate symptoms and 24% of them have severe symptoms.

This study consistent with the findings of **Ostling, Svante, MD., PhD., (2007) AJGP,** measured the psychiatric symptoms by the use of comprehensive psychopathological rating scale that the one year prevalence of any psychiatric symptoms was **Grandiosity 70%** (95%CI), including hallucination 67% and **depressions 76%** and the authors found that high prevalence of psychiatric symptoms had an increased rates in elderly and very older persons.

This study findings consistent with the findings of **Rebeca L. Toader[*], Mihaela Bucuță[**], Alina Gaboran(2013)** in their study they identified that

the clients suffering from paranoid schizophrenia have serious disturbances in ego development, self-esteem and **self-identity, emotional disturbance**, and reduced quality of life.

Objective III: To assess the psychiatric symptoms among paranoid schizophrenia clients after art therapy.

In this study the investigator identified that the post test level of BPRS score of clients after administering art therapy. 72.0% of them have the mild score, 28.0% of them have moderate BPRS score.

This study findings was not consistent with the findings of randomised trial the mental health and global functioning of people with schizophrenia **was not improved** by offering a place in a weekly art therapy group in addition to their standard care. Those randomised to weekly group art therapy had similar levels of global functioning and mental health as those randomised to an activity control group over a two year period, except that the activity control group had a greater reduction in positive symptoms of schizophrenia at 24 months. People offered a place in an art therapy group were more likely to attend sessions than those offered a place in an art activity.

Objective IV : To determine the effectiveness of art therapy by comparing pre and post test levels of BPRS score among paranoid schizophrenia clients.

This study shows the effectiveness of art therapy in the reduction score of BPRS scale for psychiatric symptoms of paranoid schizophrenia were 35% reduction in depression 34% reduction in anxiety and hostility 33% reduction in elated mood, grandiosity, 32 % in suicidality, guilt, and bizarre behavior but there was only 28% reduction in suspiciousness proves the hypothesis H_1.

In this study the investigator found in pretest that clients have 119.04 score where as in posttest they have 70.76 score, so the difference is 48.28. This difference between pretest and posttest is large and it is statistically significant***. Differences between pretest and posttest score was analyzed using paired t-test.***

This study findings were similar with the findings of (**MATISSE 2012**) investigation with the hypotheses that the clinical effectiveness of group art therapy delivered in the MATISSE trial was related to (a) the severity of negative symptoms of paranoid schizophrenia and (b) having a preference for the art therapy intervention. They explored that there was an effective result of previous experience of art therapy (29 %) in reducing negative symptoms of schizophrenia clients.

. In this study a meta-analysis was performed on both published and unpublished art-based intervention studies in order to find both an overall effect size (ES) and moderating factors that impact the outcome of art therapy on anxiety-related symptoms in clients. This meta-analysis included 24 studies and found art therapy to have a moderate overall ES of 0.53 (with a 95% confidence interval (CI) of 0.36 to 0.71) for reducing anxiety symptoms. **(Hirai & Clum, 2006)**

Objective V: To associate the level of psychiatric symptoms level among paranoid schizophrenia clients with selected demographic variables.

In this study the investigator found the association between the level of BPRS reduction score with the socio demographic variables. age group of above 31 years to 40 years, graduates and the clients getting more monthly income are reduced more psychiatric symptoms (BPRS score). Using chi square test those groups were identified that they were statistically significance groups.(p=0.005) for age and monthly income group and (p=0.01) significance for education level groups with psychiatric symptoms proves the hypothesis.$H_{2.}$

This study findings consistent with the findings of [**Sarah C. Slayton and et al (2000)**] in their article they identified the measured outcomes of art therapy effectiveness with all ages of clinical and nonclinical populations**.** Although numerous studies blend art therapy with other modalities, this review is limited to studies that isolate art therapy as the specific intervention. The results of this review suggest that there is a small body of quantifiable data to support the claim that art therapy is effective in treating variety of symptoms, age groups, and **other demographic variables reveals there was more effectiveness in more educated clients and elderly clients.**

CHAPTER VII

CONCLUSION AND RECOMMENDATION

Art therapy is an effective intervention for paranoid schizophrenia clients. As an adjunctive process, art therapy has proven to be an effective intervention for reducing psychiatric symptoms among paranoid schizophrenia clients. Art therapy helps the clients through ventilation and expression of their inner feelings.

7.1. Implications of the study:

The finding of the study has implications for nursing education, nursing practice, nursing research and nursing administration.

7.1.1. Nursing practice

- Psychiatric nurse must have the skills in teaching about improving psychiatric symptoms.
- Self-instructional material regarding improvement of psychiatric symptoms can be distributed to the people.
- The nurse must have the skills to avoid manual pressure.
- There is no need for any specific preparation to provide art therapy.

7.1.2. Nursing education

- Nursing curriculum focuses to develop skills in identifying the psychotic symptoms and its management.
- Conferences, workshops and seminars can be held for nurses to reduce psychotic symptoms and to manage the symptoms.
- Arrange in-service education to update their knowledge regarding positive and negative symptoms of paranoid schizophrenia and management of symptoms.

- Make available literature related to art therapy.
- Arrange the CAM and AYUSH programme

7.1.3. Nursing administration

- Proposed to health administration to strategically plan and meet the health needs of risk group.
- The administration both private and Govt. sectors should take initiatives to improve mental function.
- The administration can encourage the nurses for conducting research aspects for improving psychiatric symptoms.
- The administration can organize conferences, workshops and seminars on improving psychiatric symptoms through various therapies like art therapy for nurses working in the hospital and other health care setting.

7.1.4 Nursing research

- This study will be a valuable reference material for further researcher.
- The results of study encourage the management to encourage art therapy for improving psychiatric symptoms.
- Adequate allocation of funds, manpower, time, adequate training should be provided to the nurses for conducting this research.
- Research can be done to find out the effectiveness of art therapy which helps to improve psychiatric symptoms among paranoid schizophrenia clients.

7.2. Limitation of the study

- The study was limited to the paranoid schizophrenia clients.
- The study was limited to the inclients of Institute of Mental Health, Kilpauk.
- The paranoid schizophrenia clients who are interested in drawing.
- The data collection was restricted only for 4 weeks.
- The mental function level was assessed based on the score obtained.

7.3 Recommendation for further study

Keeping in view, the finding of the present study can be used as a guide for future research.

- A similar study can be undertaken on a large sample in different setting
- A similar study can be conducted to assess the effectiveness of other complimentary therapies on improving mental function.
- A longitudinal study can be undertaken to find out the long term effect of art therapy in improving psychiatric symptoms.

Conclusion

Education in evidence based care gives the opportunity to nurses in improving their ability to use theoretical knowledge in practice.

This study concluded that nurse's role in improving mental function is mandatory. Through art therapy, the paranoid schizophrenia clients have reduced score of BPRS about 28.7%. So this level of reduction of BPRS score reflects the effectiveness of art therapy. So the nurses should educate the paranoid schizophrenia clients to manage mental functions through ventilation and communication through art therapy in all settings.

This chapter enlightens the importance of this research and reveals that the reduction in the level of BPRS score among paranoid schizophrenia clients is significant and the art therapy is effective in reducing psychiatric symptoms.

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INSTITUTIONAL ETHICS COMMITTEE
MADRAS MEDICAL COLLEGE, CHENNAI-3

EC Reg No.ECR/270/Inst./TN/2013
Telephone No. 044 25305301
Fax : 044 25363970

CERTIFICATE OF APPROVAL

To
Mrs. YAMUNA DEVI.P
M.Sc., (Nursing)
College of Nursing
Madras Medical College,
Chennai – 600 003.

Dear Mrs. YAMUNA DEVI.P,

The Institutional Ethics Committee has considered your request and approved your study titled **A STUDY TO ASSESS THE EFFECTIVENESS OF ART THERAPY AMONG PARANOID SCHIZOPHRENIA PATIENTS AT INSTITUTE OF MENTAL HEALTH, KILPAUK.** **No.32102014.**

The following members of Ethics Committee were present in the meeting held on 21.10.2014 conducted at Madras Medical College, Chennai-3.

1. Dr.C.Rajendran, M.D.,	: Chairperson
2. Dr.R.Vimala, M.D., Dean, MMC, Ch-3	: Deputy Chairperson
3. Prof.B.Kalaiselvi, M.D., Vice-Principal, MMC, Ch-3	: Member Secretary
4. Prof.R.Nandhini, M.D., Inst.of Pharmacology, MMC	: Member
5. Prof.K.Ramadevi, Director i/c, Inst.of Biochemistry, MMC	: Member
6. Prof.Saraswathy, M.D., Director, Pathology, MMC, Ch-3	: Member
7. Prof.S.G.Sivachidambaram, M.D., Director i/c, Inst.of Internal Medicine, MMC	: Member
8. Dr.Raghumani, M.S., Professor of Surgery, MMC	: Member
9. Thiru S.Rameshkumar, Administrative Officer	: Lay Person
10.Thiru S.Govindasamy, B.A., B.L.,	: Lawyer
11.Tmt.Arnold Saulina, M.A., MSW.,	: Social Scientist

We approve the proposal to be conducted in its presented form.

The Institutional Ethics Committee expects to be informed about the progress of the study and SAE occurring in the course of the study, any changes in the protocol and patients information/informed consent and asks to be provided a copy of the final report.

Member Secretary, Ethics Committee

CERTIFICATE FOR CONTENT VALIDITY

This is to certify that the tool constructed by Ms.P.Yamunadevi M.Sc. Nursing II year, College of Nursing, Madras Medical College which is to be used in her study titled **"A study to assess the effectiveness of art therapy among paranoid schizophrenia patients at Institute of Mental Health, Kilpauk, Chennai.**has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide. Then she can proceed to do the research.

B. SUDHAKARAN, M.A.,M.Phil(Cl.Psy).,
RCI Registration No: A07047
Assistant Professor of Psychology cum
Clinical Psychologist,
Institute of Mental Health, Chennai-10.

SIGNATURE WITH SEAL

NAME : B. SUDHAKARAN

DESIGNATION : ASST. PROF OF PSYCHOLOGY CUM CLINICAL PSYCHOLOGIST

COLLEGE : INSTITUTE OF MENTAL HEALTH

PLACE : CHENNAI

DATE :

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SIGNATURE WITH SEAL

Karthik Rajaram,
Director - Rehab Program,

NAME : KARTHIK. RAJARAM.

DESIGNATION : DIRECTOR.

COLLEGE : STEPS REHABILITATION CENTER,
1856, TRICHY ROAD,
RAMANATHAPURAM, CBE

PLACE : COIMBATORE

DATE : 31/7/2015

STEPS REHABILITATION CENTRE
UNIT II
1850, Trichy Road,
Ramanathapuram,
Coimbatore
INDIA - 641 045.
+91 9894747660
(A UNIT OF STEPS GROUPS)

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SIGNATURE WITH SEAL

Apollo College of Nursing Chennai - 600 095

NAME : K. Vijayalakshmi.

DESIGNATION : Professor.

COLLEGE : Apollo College of Nursing, Chennai.

PLACE : Chennai.

DATE : 31.07.2015.

CERTIFICATE FOR CONTENT VALIDITY

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SIGNATURE WITH SEAL

SUPERINTENDENT & SURGEON
INSTITUTE OF MENTAL HEALTH
KILPAUK, CHENNAI 10

NAME : DR.V.Venkatesh Mathan kumar

DESIGNATION : Associate professor

COLLEGE : Madras Medical College

PLACE : chennai

DATE :

CERTIFICATE FOR CONTENT VALIDITY

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SIGNATURE WITH SEAL

MADHA COLLEGE OF NURSING
15 JUL 2015
CHENNAI - 600 069

NAME : Mrs. CATHERINE BABY SUHASINI

DESIGNATION : LECTURER

COLLEGE : MADHA COLLEGE OF NURSING

PLACE : CHENNAI

DATE : 15.07.15

SOCIO DEMOGRAPHIC DATA OF THE PATIENT

1) Age

a) Below 21 years ☐

b) 21 to 40 years ☐

c) 41 to 60 years ☐

d) above 60 years ☐

2) Gender

a) Male ☐

b) Female ☐

3) Education

a) No formal ☐

b) Schooling ☐

c) College grade ☐

d) Above college grade ☐

4) Occupation

a) Labor ☐

b) Private company ☐

c) Government ☐

d) others ☐

5) Income

a) < Rs.6000 ☐

b) Rs.6001 to Rs.10,000 ☐

c) Rs.10,001 to Rs.15,000 ☐

d) > Rs. 15,000 ☐

6) Marital status

- **a)** Single ☐
- **b)** Married ☐
- **c)** Widowed ☐
- **d)** divorced/separated ☐

7) Religion

- a) Hindu ☐
- b) Muslim ☐
- c) Christian ☐
- d) Others ☐

8) Locality

- a) Urban ☐
- b) Rural ☐

9) Type of family

- a) Nuclear ☐
- b) Joint ☐
- c) Extended ☐

10) Hobbies

- a) Reading ☐
- b) Singing ☐
- c) Drawing ☐
- d) Others ☐

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Introduction

This section reproduces an interview schedule, symptom definitions, and specific anchor points for rating symptoms on the BPRS. Clinicians intending to use the BPRS should also consult the detailed guidelines for administration contained in the reference below.

Scale Items and Anchor Points

Rate items 1-14 on the basis of individual's self-report. Note items 7, 12 and 13 are also rated on the basis of observed behaviour. Items 15-24 are rated on the basis of observed behaviour and speech.

1. Somatic Concern

Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the individual, whether complaints have realistic bases or not. Somatic delusions should be rated in the severe range with or without somatic concern.

Note: be sure to assess the degree of impairment due to somatic concerns only and not other symptoms, e.g., depression. In addition, if the individual rates 6 or 7 due to somatic delusions, then you must rate Unusual Thought Content at least 4 or above.

2. Very mild Occasional somatic concerns that tend to be kept to self.

3. Mild Occasional somatic concerns that tend to be voiced to others (e.g., family, doctor).

4. Moderate Frequent expressions of somatic concern or exaggerations of existing ills OR some preoccupation, but no impairment in functioning. Not delusional.

5. Moderately severe Frequent expressions of somatic concern or exaggerations of existing ills OR some preoccupation and moderate impairment of functioning. Not delusional.

6. Severe Preoccupation with somatic complaints with much impairment in functioning OR somatic delusions without acting on them or disclosing to others.

7. Extremely severe Preoccupation with somatic complaints with severe impairment in functioning OR somatic delusions that tend to be acted on or disclosed to others. "Have you been concerned about your physical health?" "Have you had any physical illness or seen a medical doctor lately? (What does your doctor say is wrong? How serious is it?)" "Has anything changed regarding your appearance?" "Has it interfered with your ability to perform your usual activities and/or work?" "Did you ever feel that parts of your body had changed or stopped working?" [If individual reports any somatic concerns/delusions, ask the following]: "How often are you concerned about [use individual's description]?" "Have you expressed any of these concerns to others?"

2.1. Anxiety

Reported apprehension, tension, fear, panic or worry. Rate only the individual's statements - not observed anxiety which is rated under Tension.

2. Very mild Reports some discomfort due to worry OR infrequent worries that occur more than usual for most normal individuals.

3. Mild Worried frequently but can readily turn attention to other things.

4. Moderate Worried most of the time and cannot turn attention to other things easily but no impairment in functioning OR occasional anxiety with autonomic accompaniment but no impairment in functioning.

5. Moderately Severe Frequent, but not daily, periods of anxiety with autonomic accompaniment OR some areas of functioning are disrupted by anxiety or worry.

6. Severe Anxiety with autonomic accompaniment daily but not persisting throughout the day OR many areas of functioning are disrupted by anxiety or constant worry.

7. Extremely Severe Anxiety with autonomic accompaniment persisting throughout the day OR most areas of functioning are disrupted by anxiety or

constant worry. "Have you been worried a lot during [mention time frame]? Have you been nervous or apprehensive? (What do you worry about?)" "Are you concerned about anything? How about finances or the future?" "When you are feeling nervous, do your palms sweat or does your heart beat fast (or shortness of breath, trembling, choking)?" [If individual reports anxiety or autonomic accompaniment, ask the following]: "How much of the time have you been [use individual's description]?" "Has it interfered with your ability to perform your usual activities/work?"

3. 1.Depression

Include sadness, unhappiness, anhedonia and preoccupation with depressing topics (can't attend to TV or conversations due to depression), hopeless, loss of self-esteem (dissatisfied or disgusted with self or feelings of worthlessness). Do not include vegetative symptoms, e.g., motor retardation, early waking or the amotivation that accompanies the deficit syndrome.

2. Very mild Occasionally feels sad, unhappy or depressed.

3. Mild Frequently feels sad or unhappy but can readily turn attention to other things.

4. Moderate Frequent periods of feeling very sad, unhappy, moderately depressed, but able to function with extra effort.

5. Moderately Severe Frequent, but not daily, periods of deep depression OR some areas of functioning are disrupted by depression.

6. Severe Deeply depressed daily but not persisting throughout the day OR many areas of functioning are disrupted by depression.

7. Extremely Severe Deeply depressed daily OR most areas of functioning are disrupted by depression. "How has your mood been recently? Have you felt depressed (sad, down, unhappy, as if you didn't care)?" "Are you able to switch your attention to more pleasant topics when you want to?" "Do you find that you have lost interest in or get less pleasure from things you used to enjoy, like family, friends, hobbies, watching TV, eating?" [If individual reports feelings of depression, ask the following]: "How long do these feelings last?" "Has it interfered with your ability to perform your usual activities?"

4. Suicidality 1. Expressed desire, intent, or actions to harm or kill self.

2. Very mild Occasional feelings of being tired of living. No overt suicidal thoughts.

3. Mild Occasional suicidal thoughts without intent or specific plan OR he/she feels they would be better off dead.

4. Moderate Suicidal thoughts frequent without intent or plan.

5. Moderately Severe Many fantasies of suicide by various methods. May seriously consider making an attempt with specific time and plan OR impulsive suicide attempt using non-lethal method or in full view of potential saviours.

6. Severe Clearly wants to kill self. Searches for appropriate means and time, OR potentially serious suicide attempt with individual knowledge of possible rescue.

7. Extremely Severe Specific suicidal plan and intent (e.g., "as soon as I will do it by doing X"), OR suicide attempt characterised by plan individual thought was lethal or attempt in secluded environment. "Have you felt that life wasn't worth living? Have you thought about harming or killing yourself? Have you felt tired of living or as though you would be better off dead? Have you ever felt like ending it all?" [If individual reports suicidal ideation, ask the following]: "How often have you thought about [use individual's description]?" "Did you (Do you) have a specific plan?"

5. Guilt 1. Overconcern or remorse for past behaviour. Rate only individual's statements, do not infer guilt feelings from depression, anxiety, or neurotic defences. Note: if the individual rates 6 or 7 due to delusions of guilt, then you must rate Unusual Thought Content at least 4 or above, depending on level of preoccupation and impairment.

2. Very mild Concerned about having failed someone, or at something, but not preoccupied. Can shift thoughts to other matters easily.

3. Mild Concerned about having failed someone, or at something, with some preoccupation. Tends to voice guilt to others.

4. Moderate Disproportionate preoccupation with guilt, having done wrong, injured others by doing or failing to do something, but can readily turn attention to other things.

5. Moderately Severe Preoccupation with guilt, having failed someone or at something, can turn attention to other things, but only with great effort. Not delusional.

6. Severe Delusional guilt OR unreasonable self-reproach very out of proportion to circumstances. Moderate preoccupation present.

7. Extremely Severe Delusional guilt OR unreasonable self-reproach grossly out of proportion to circumstances. Individual is very preoccupied with guilt and is likely to disclose to others or act on delusions. "Is there anything you feel guilty about? Have you been thinking about past problems?" "Do you tend to blame yourself for things that have happened?" "Have you done anything you're still ashamed of?" [If individual reports guilt/remorse/delusions, ask the following]: "How often have you been thinking about [use individual's description]?" "Have you disclosed your feelings of guilt to others?"

6.1. Hostility Animosity, contempt, belligerence, threats, arguments, tantrums, property destruction, fights, and any other expression of hostile attitudes or actions. Do not infer hostility from neurotic defences, anxiety or somatic complaints. Do not include incidents of appropriate anger or obvious self-defence.

2. Very mild Irritable or grumpy, but not overtly expressed.

3.Mild Argumentative or sarcastic.

4. Moderate Overtly angry on several occasions OR yelled at others excessively.

5. Moderately Severe Has threatened, slammed about or thrown things.

6. Severe Has assaulted others but with no harm likely, e.g., slapped or pushed, OR destroyed property, e.g., knocked over furniture, broken windows.

7. Extremely Severe Has attacked others with definite possibility of harming them or with actual harm, e.g., assault with hammer or weapon. "How have you been getting along with people (family, co-workers, etc.)?" "Have you

been irritable or grumpy lately? (How do you show it? Do you keep it to yourself?" "Were you ever so irritable that you would shout at people or start fights or arguments? (Have you found yourself yelling at people you didn't know?)" "Have you hit anyone recently?"

7. Elevated Mood

A pervasive, sustained and exaggerated feeling of well-being, cheerfulness, euphoria (implying a pathological mood), optimism that is out of proportion to the circumstances. Do not infer elation from increased activity or from grandiose statements alone.

2. Very mild Seems to be very happy, cheerful without much reason.

3. Mild Some unaccountable feelings of well-being that persist.

4. Moderate Reports excessive or unrealistic feelings of well-being, cheerfulness, confidence or optimism inappropriate to circumstances, some of the time. May frequently joke, smile, be giddy, or overly enthusiastic OR few instances of marked elevated mood with euphoria.

5. Moderately Severe Reports excessive or unrealistic feelings of well-being, confidence or optimism inappropriate to circumstances, much of the time. May describe feeling `on top of the world', `like everything is falling into place', or `better than ever before', OR several instances of marked elevated mood with euphoria.

6. Severe Reports many instances of marked elevated mood with euphoria OR mood definitely elevated almost constantly throughout interview and inappropriate to content.

7. Extremely Severe Individual reports being elated or appears almost intoxicated, laughing, joking, giggling, constantly euphoric, feeling invulnerable, all inappropriate to immediate circumstances. "Have you felt so good or high that other people thought that you were not your normal self?" "Have you been feeling cheerful and `on top of the world' without any reason?" [If individual reports elevated mood/euphoria, ask the following]: "Did it seem like more than just feeling good?" "How long did that last?"

8. Grandiosity

Exaggerated self-opinion, self-enhancing conviction of special abilities or powers or identity as someone rich or famous. Rate only individual's statements about himself, not his/her demeanour. Note: if the individual rates 6 or 7 due to grandiose delusions, you must rate Unusual Thought Content at least 4 or above.

2. Very mild Feels great and denies obvious problems, but not unrealistic.

3. Mild Exaggerated self-opinion beyond abilities and training.

4. Moderate Inappropriate boastfulness, e.g., claims to be brilliant, insightful or gifted beyond realistic proportions, but rarely self-discloses or acts on these inflated selfconcepts. Does not claim that grandiose accomplishments have actually occurred.

5. Moderately Severe Same as 4 but often self-discloses and acts on these grandiose ideas. May have doubts about the reality of the grandiose ideas. Not delusional.

6. Severe Delusional - claims to have special powers like ESP, to have millions of dollars, invented new machines, worked at jobs when it is known that he/she was never employed in these capacities, be Jesus Christ, or the Prime Minister. Individual may not be very preoccupied.

7. Extremely Severe Delusional - same as 6 but individual seems very preoccupied and tends to disclose or act on grandiose delusions. "Is there anything special about you? Do you have any special abilities or powers? Have you thought that you might be somebody rich or famous?" [If the individual reports any grandiose ideas/delusions, ask the following]: "How often have you been thinking about [use individuals description]? Have you told anyone about what you have been thinking? Have you acted on any of these ideas?"

9. Suspiciousness

Expressed or apparent belief that other persons have acted maliciously or with discriminatory intent. Include persecution by supernatural or other non-human agencies (e.g., the devil). Note: ratings of 3 or above should also be rated under Unusual Thought Content.

2. Very mild Seems on guard. Reluctant to respond to some `personal' questions. Reports being overly self-conscious in public.

3. Mild Describes incidents in which others have harmed or wanted to harm him/her that sound plausible. Individual feels as if others are watching, laughing or criticising him/her in public, but this occurs only occasionally or rarely. Little or no preoccupation.

4. Moderate Says other persons are talking about him/her maliciously, have negative intentions or may harm him/her. Beyond the likelihood of plausibility, but not delusional. Incidents of suspected persecution occur occasionally (less than once per week) with some preoccupation.

5. Moderately Severe Same as 4, but incidents occur frequently, such as more than once per week. Individual is moderately preoccupied with ideas of persecution OR individual reports persecutory delusions expressed with much doubt (e.g., partial delusion).

6. Severe Delusional - speaks of Mafia plots, the FBI or others poisoning his/her food, persecution by supernatural forces.

7. Extremely Severe Same as 6, but the beliefs are bizarre or more preoccupying.

Individual tends to disclose or act on persecutory delusions.

"Do you ever feel uncomfortable in public? Does it seem as though others are watching you? Are you concerned about anyone's intentions toward you? Is anyone going out of their way to give you a hard time, or trying to hurt you? Do you feel in any danger?" [If individual reports any persecutory ideas/delusions, ask the following]: "How often have you been concerned that [use individual's description]? Have you told anyone about these experiences?"

10. Hallucinations

Reports of perceptual experiences in the absence of relevant external stimuli. When rating degree to which functioning is disrupted by hallucinations, include preoccupation with the content and experience of the hallucinations, as well as functioning disrupted by acting out on the hallucinatory content (e.g., engaging in deviant behaviour due to command hallucinations). Include thoughts aloud

(`gedenkenlautwerden') or pseudohallucinations (e.g., hears a voice inside head) if a voice quality is present.

2. Very mild While resting or going to sleep, sees visions, smells odours or hears voices, sounds, or whispers in the absence of external stimulation, but no impairment in functioning.

3. Mild While in a clear state of consciousness, hears a voice calling the individual's name, experiences non-verbal auditory hallucinations (e.g., sounds or whispers), formless visual hallucinations or has sensory experiences in the presence of a modalityrelevant stimulus (e.g., visual illusions) infrequently (e.g., 1-2 times per week) and with no functional impairment.

4. Moderate Occasional verbal, visual, gustatory, olfactory or tactile hallucinations with no functional impairment OR non-verbal auditory hallucinations/visual illusions more than infrequently or with impairment.

5. Moderately Severe Experiences daily hallucinations OR some areas of functioning are disrupted by hallucinations.

6. Severe Experiences verbal or visual hallucinations several times a day OR many areas of functioning are disrupted by these hallucinations.

7. Extremely Severe Persistent verbal or visual hallucinations throughout the day OR most areas of functioning are disrupted by these hallucinations. "Do you ever seem to hear your name being called?" "Have you heard any sounds or people talking to you or about you when there has been nobody around?

[If hears voices]: "What does the voice/voices say? Did it have a voice quality?" "Do you ever have visions or see things that others do not see? What about smell odours that others do not smell?" [If the individual reports hallucinations, ask the following]: "Have these experiences interfered with your ability to perform your usual activities/work? How do you explain them? How often do they occur?"

11. Unusual thought content

Unusual, odd, strange, or bizarre thought content. Rate the degree of unusualness, not the degree of disorganisation of speech. Delusions are patently absurd, clearly false or bizarre ideas that are expressed with full conviction.

Consider the individual to have full conviction if he/she has acted as though the delusional belief was true. Ideas of reference/persecution can be differentiated from delusions in that ideas are expressed with much doubt and contain more elements of reality. Include thought insertion, withdrawal and broadcast. Include grandiose, somatic and persecutory delusions even if rated elsewhere. Note: if Somatic Concern, Guilt, Suspiciousness or Grandiosity are rated 6 or 7 due to delusions, then Unusual Thought Content must be rated 4 or above.

2. Very mild Ideas of reference (people may stare or may laugh at him), ideas of persecution (people may mistreat him). Unusual beliefs in psychic powers, spirits, UFOs, or unrealistic beliefs in one's own abilities. Not strongly held. Some doubt.

3. Mild Same as 2, but degree of reality distortion is more severe as indicated by highly unusual ideas or greater conviction. Content may be typical of delusions (even bizarre), but without full conviction. The delusion does not seem to have fully formed, but is considered as one possible explanation for an unusual experience.

4. Moderate Delusion present but no preoccupation or functional impairment. May be an encapsulated delusion or a firmly endorsed absurd belief about past delusional circumstances.

5. Moderately Severe Full delusion(s) present with some preoccupation OR some areas of functioning disrupted by delusional thinking.

6. Severe Full delusion(s) present with much preoccupation OR many areas of functioning are disrupted by delusional thinking.

7. Extremely Severe Full delusion(s) present with almost total preoccupation OR most areas of functioning disrupted by delusional thinking. "Have you been receiving any special messages from people or from the way things are arranged around you? Have you seen any references to yourself on TV or in the newspapers?" "Can anyone read your mind?" "Do you have a special relationship with God?" "Is anything like electricity, X-rays, or radio waves affecting you?" "Are thoughts put into your head that are not your own?" "Have you felt that you were under the control of another person or force?" [If

individual reports any odd ideas/delusions, ask the following]: "How often do you think about [use individual's description]?" "Have you told anyone about these experiences? How do you explain the things that have been happening [specify]?"

RATE ITEMS 12-13 ON THE BASIS OF INDIVIDUAL'S SELF-REPORT AND OBSERVED BEHAVIOUR.

12. Bizarre behaviour

Reports of behaviours which are odd, unusual, or psychotically criminal. Not limited to interview period. Include inappropriate sexual behaviour and inappropriate affect.

2. Very mild Slightly odd or eccentric public behaviour, e.g., occasionally giggles to self, fails to make appropriate eye contact, that does not seem to attract the attention of others OR unusual behaviour conducted in private, e.g., innocuous rituals, that would not attract the attention of others.

3. Mild Noticeably peculiar public behaviour, e.g., inappropriately loud talking, makes inappropriate eye contact, OR private behaviour that occasionally, but not always, attracts the attention of others, e.g., hoards food, conducts unusual rituals, wears gloves indoors.

4. Moderate Clearly bizarre behaviour that attracts or would attract (if done privately) the attention or concern of others, but with no corrective intervention necessary. Behaviour occurs occasionally, e.g., fixated staring into space for several minutes, talks back to voices once, inappropriate giggling/laughter on 1-2 occasions, talking loudly to self.

5. Moderately Severe Clearly bizarre behaviour that attracts or would attract (if done privately) the attention of others or the authorities, e.g., fixated staring in a socially disruptive way, frequent inappropriate giggling/laughter,occasionally responds to voices, or eats non-foods.

6. Severe Bizarre behaviour that attracts attention of others and intervention by

authorities, e.g., directing traffic, public nudity, staring into space for long periods, carrying on a conversation with hallucinations, frequent inappropriate giggling/laughter.

7. Extremely Severe Serious crimes committed in a bizarre way that attract the attention of others and the control of authorities, e.g., sets fires and stares at flames OR almost constant bizarre behaviour, e.g., inappropriate giggling/laughter, responds only to hallucinations and cannot be engaged in interaction."Have you done anything that has attracted the attention of others?" "Have you done anything that could have gotten you into trouble with the police?" "Have you done anything that seemed unusual or disturbing toothers?"

13. Self-neglect

Hygiene, appearance, or eating behaviour below usual expectations, below socially acceptable standards or life threatening.

2. Very mild Hygiene/appearance slightly below usual community standards, e.g., shirt out of pants, buttons unbuttoned, shoe laces untied, but no social or medical consequences.

3. Mild Hygiene/appearance occasionally below usual community standards, e.g., irregular bathing, clothing is stained, hair uncombed, occasionally skips an important meal. No social or medical consequences.

4. Moderate Hygiene/appearance is noticeably below usual community standards, e.g., fails to bathe or change clothes, clothing very soiled, hair unkempt, needs prompting, noticeable by others OR irregular eating and drinking with minimal medical concerns and consequences.

5. Moderately Severe Several areas of hygiene/appearance are below usual community standards OR poor grooming draws criticism by others and requires regular prompting. Eating or hydration are irregular and poor, causing some medical problems.

6. Severe Many areas of hygiene/appearance are below usual community standards, does not always bathe or change clothes even if prompted. Poor grooming has caused social ostracism at school/residence/work, or required intervention. Eating erratic and poor, may require medical intervention.

7. Extremely Severe Most areas of hygiene/appearance/nutrition are extremely poor and easily noticed as below usual community standards OR hygiene/appearance/nutrition require urgent and immediate medical intervention. "How has your grooming been lately? How often do you change your clothes? How often do you take showers? Has anyone (parents/staff) complained about your grooming or dress? Do you eat regular meals?"

14. Disorientation

Does not comprehend situations or communications, such as questions asked during the entire BPRS interview. Confusion regarding person, place, or time. Do not rate if incorrect responses are due to delusions.

2. Very mild Seems muddled or mildly confused 1-2 times during interview. Oriented to person, place and time.

3. Mild Occasionally muddled or mildly confused 3-4 times during interview. Minor inaccuracies in person, place, or time, e.g., date off by more than 2 days, or gives wrong division of hospital or community centre.

4. Moderate Frequently confused during interview. Minor inaccuracies in person, place, or time are noted, as in 3 above. In addition, may have difficulty remembering general information, e.g., name of Prime Minister.

5. Moderately Severe Markedly confused during interview, or to person, place, or time. Significant inaccuracies are noted, e.g., date off by more than one week, or cannot give correct name of hospital. Has difficulty remembering personal information, e.g., where he/she was born or recognising familiar people.

6. Severe Disoriented as to person, place, or time, e.g., cannot give correct month and year. Disoriented in 2 out of 3 spheres.

7. Extremely Severe Grossly disoriented as to person, place, or time, e.g., cannot give name or age. Disoriented in all three spheres. "May I ask you some standard questions as we ask everybody?" "How old are you? What is the date [allow 2 days]" "What is this place called? In which year were you born? Who is the Prime Minister?"

RATE ITEMS 15-24 ON THE BASIS OF OBSERVED BEHAVIOUR AND SPEECH.

15. Conceptual disorganisation

Degree to which speech is confused, disconnected, vague or disorganised. Rate tangentiality, circumstantiality, sudden topic shifts, incoherence, derailment, blocking, neologisms, and other speech disorders. Do not rate content of speech.

2. Very mild Peculiar use of words or rambling but speech is comprehensible.

3. Mild Speech a bit hard to understand or make sense of due to tangentiality, circumstantiality, or sudden topic shifts.

4. Moderate Speech difficult to understand due to tangentiality, circumstantiality,idiosyncratic speech, or topic shifts on many occasions OR 1-2 instances of incoherent phrases.

5. Moderately Severe Speech difficult to understand due to circumstantiality, tangentiality, neologisms, blocking or topic shifts most of the time, OR 3-5 instances of incoherent phrases.

6. Severe Speech is incomprehensible due to severe impairment most of the time. Many BPRS items cannot be rated by self-report alone.

7. Extremely Severe Speech is incomprehensible throughout interview.

16. Blunted affect 1. Restricted range in emotional expressiveness of face, voice, and gestures. Marked indifference or flatness even when discussing distressing topics. In the case of euphoric or dysphoric individuals, rate Blunted Affect if a flat quality is also clearly present.

2. Very mild Emotional range is slightly subdued or reserved but displays appropriate facial expressions and tone of voice that are within normal limits.

3. Mild Emotional range overall is diminished, subdued or reserved, without many spontaneous and appropriate emotional responses. Voice tone is slightly monotonous.

4. Moderate Emotional range is noticeably diminished, individual doesn't show emotion, smile or react to distressing topics except infrequently. Voice tone is monotonous or there is noticeable decrease in spontaneous movements. Displays of emotion or gestures are usually followed by a return to flattened affect.

5. Moderately Severe Emotional range very diminished, individual doesn't show emotion, smile, or react to distressing topics except minimally, few gestures, facial expression does not change very often. Voice tone is monotonous much of the time.

6. Severe Very little emotional range or expression. Mechanical in speech and gestures most of the time. Unchanging facial expression. Voice tone is mono tonous most of the time.

7. Extremely Severe Virtually no emotional range or expressiveness, stiff movements. Voice tone is monotonous all of the time. Use the following probes at end of interview to assess emotional responsivity: "Have you heard any good jokes lately? Would you like to hear a joke?"

17. Emotional withdrawal

Deficiency in individual's ability to relate emotionally during interview situation. Use your own feeling as to the presence of an `invisible barrier' between individual and interviewer. Include withdrawal apparently due to psychotic processes.

2. Very mild Lack of emotional involvement shown by occasional failure to make reciprocal comments, appearing preoccupied, or smiling in a stilted manner, but spontaneously engages the interviewer most of the time.

3. Mild Lack of emotional involvement shown by noticeable failure to make reciprocal comments, appearing preoccupied, or lacking in warmth, but responds to interviewer when approached.

4. Moderate Emotional contact not present much of the interview because individual does not elaborate responses, fails to make eye contact, doesn't seem to care if interviewer is listening, or may be preoccupied with psychotic material.

5. Moderately Severe Same as 4 but emotional contact not present most of the interview.

6. Severe Actively avoids emotional participation. Frequently unresponsive or responds with yes/no answers (not solely due to persecutory delusions). Responds with only minimal affect.

7. Extremely Severe Consistently avoids emotional participation. Unresponsive or responds with yes/no answers (not solely due to persecutory delusions). May leave during interview or just not respond at all.

18. Motor retardation

Reduction in energy level evidenced by slowed movements and speech, reduced body tone, decreased number of spontaneous body movements. Rate on the basis of observed behaviour of the individual only. Do not rate on the basis of individual's subjective impression of his own energy level. Rate regardless of medication effects.

2. Very mild Slightly slowed or reduced movements or speech compared to most people.

3. Mild Noticeably slowed or reduced movements or speech compared to most people.

4. Moderate Large reduction or slowness in movements or speech.

5. Moderately Severe Seldom moves or speaks spontaneously OR very mechanical or stiff movements

6. Severe Does not move or speak unless prodded or urged.

7. Extremely Severe Frozen, catatonic.

19. Tension

Observable physical and motor manifestations of tension, `nervousness' and agitation. Self-reported experiences of tension should be rated under the item on anxiety. Do not rate if restlessness is solely akathisia, but do rate if akathisia is exacerbated by tension.

2. Very mild More fidgety than most but within normal range. A few transient signs of tension, e.g., picking at fingernails, foot wagging, scratching scalp several times or finger tapping.

3. Mild Same as 2, but with more frequent or exaggerated signs of tension.

4. Moderate Many and frequent signs of motor tension with one or more signs sometimes occurring simultaneously, e.g., wagging one's foot while wringing hands together. There are times when no signs of tension are present.

5. Moderately Severe Many and frequent signs of motor tension with one or more signs often occurring simultaneously. There are still rare times when no signs of tension are present.

6. Severe Same as 5, but signs of tension are continuous.

7. Extremely Severe Multiple motor manifestations of tension are continuously present, e.g., continuous pacing and hand wringing.

20. Unco-operativeness

Resistance and lack of willingness to co-operate with the interview. The uncooperativeness might result from suspiciousness. Rate only unco-operativeness in relation to the interview, no behaviours involving peers and relatives.

2. Very mild Shows non-verbal signs of reluctance, but does not complain or argue.

3. Mild Gripes or tries to avoid complying, but goes ahead without argument.

4. Moderate Verbally resists but eventually complies after questions are rephrased or repeated.

5. Moderately Severe Same as 4, but some information necessary for accurate ratings is withheld.

6. Severe Refuses to co-operate with interview, but remains in interview situation.

7. Extremely Severe Same as 6, with active efforts to escape the interview

21. Excitement

Heightened emotional tone or increased emotional reactivity to interviewer or topics being discussed, as evidenced by increased intensity of facial expressions, voice tone, expressive gestures or increase in speech quantity and speed.

2. Very mild Subtle and fleeting or questionable increase in emotional intensity. For example, at times seems keyed-up or overly alert.

3. Mild Subtle but persistent increase in emotional intensity. For example, lively use of gestures and variation in voice tone.

4. Moderate Definite but occasional increase in emotional intensity. For example, reacts to interviewer or topics that are discussed with noticeable emotional intensity. Some pressured speech.

5. Moderately Severe Definite and persistent increase in emotional intensity. For example, reacts to many stimuli, whether relevant or not, with considerable emotional intensity. Frequent pressured speech.

6. Severe Marked increase in emotional intensity. For example, reacts to most stimuli with inappropriate emotional intensity. Has difficulty settling down or staying on task. Often restless, impulsive, or speech is often pressured.

7. Extremely Severe Marked and persistent increase in emotional intensity. Reacts to all stimuli with inappropriate intensity, impulsiveness. Cannot settle down or stay on task. Very restless and impulsive most of the time. Constant pressured speech.

22. Distractibility 1. Degree to which observed sequences of speech and actions are interrupted by stimuli unrelated to the interview. Distractibility is rated when the individual shows a change in the focus of attention as characterised by a pause in speech or a marked shift in gaze. Individual's attention may be drawn to noise in adjoining room, books on a shelf, interviewer's clothing, etc. Do not rate circumstantiality, tangentiality or flight of ideas. Also, do not rate rumination with delusional material. Rate even if the distracting stimulus cannot be identified.

2. Very mild Generally can focus on interviewer's questions with only 1 distraction or inappropriate shift of attention of brief duration.

3. Mild Individual shifts focus of attention to matters unrelated to the interview 2-3 times.

4. Moderate Often responsive to irrelevant stimuli in the room, e.g., averts gaze from the interviewer.

5. Moderately Severe Same as above, but now distractibility clearly interferes with the flow of the interview.

6. Severe Extremely difficult to conduct interview or pursue a topic due to preoccupation with irrelevant stimuli.

7. Extremely Severe Impossible to conduct interview due to preoccupation with irrelevant stimuli.

23. Motor hyperactivity 1. Increase in energy level evidenced in more frequent movement and/or rapid speech. Do not rate if restlessness is due to akathisia.

2. Very mild Some restlessness, difficulty sitting still, lively facial expressions, or somewhat talkative

3. Mild Occasionally very restless, definite increase in motor activity, lively gestures, 1-3 brief instances of pressured speech.

4. Moderate Very restless, fidgety, excessive facial expressions, or non-productive and repetitious motor movements. Much pressured speech, up to one-third of the interview.

5. Moderately Severe Frequently restless, fidgety. Many instances of excessive nonproductive and repetitious motor movements. On the move most of the time. Frequent pressured speech, difficult to interrupt. Rises on 1-2 occasions to pace.

6. Severe Excessive motor activity, restlessness, fidgety, loud tapping, noisy, etc., throughout most of the interview. Speech can only be interrupted with much effort. Rises on 3-4 occasions to pace.

7. Extremely Severe Constant excessive motor activity throughout entire interview, e.g., constant pacing, constant pressured speech with no pauses, individual can only be interrupted briefly and only small amounts of relevant information can be obtained.

24. Mannerisms and posturing

Unusual and bizarre behaviour, stylised movements or acts, or any postures which are clearly uncomfortable or inappropriate. Exclude obvious

manifestations of medication side effects. Do not include nervous mannerisms that are not odd or unusual.

2. Very mild Eccentric or odd mannerisms or activity that ordinary persons would have difficulty explaining, e.g., grimacing, picking. Observed once for a brief period.

3. Mild Same as 2, but occurring on two occasions of brief duration.

4. Moderate Mannerisms or posturing, e.g., stylised movements or acts, rocking, nodding, rubbing, or grimacing, observed on several occasions for brief periods or infrequently but very odd. For example, uncomfortable posture maintained for 5 seconds more than twice.

5. Moderately Severe Same as 4, but occurring often, or several examples of very odd mannerisms or posturing that are idiosyncratic to the individual.

6. Severe Frequent stereotyped behaviour, assumes and maintains uncomfortable or inappropriate postures, intense rocking, smearing, strange rituals or foetal posturing. Individual can interact with people and the environment for brief periods despite these behaviours.

7. Extremely Severe Same as 6, but individual cannot interact with people or the environment due to these behaviours.

BASIC PSYCHIATRIC RATING SCALE

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate,
5 = Moderately severe, 6 = Severe, 7 = Extremely severe

SL.NO.	SYMPTOMS	SCORE							
1	Somatic	0	1	2	3	4	5	6	7
2	Anxiety	0	1	2	3	4	5	6	7
3	Depression	0	1	2	3	4	5	6	7
4	Suicidality	0	1	2	3	4	5	6	7
5	Guilt	0	1	2	3	4	5	6	7
6	Hostility	0	1	2	3	4	5	6	7
7	Elated Mood	0	1	2	3	4	5	6	7
8	Grandiosity	0	1	2	3	4	5	6	7
9	Suspiciousness	0	1	2	3	4	5	6	7
10	Hallucinations	0	1	2	3	4	5	6	7
11	Unusual thought content	0	1	2	3	4	5	6	7
12	Bizarre behavior	0	1	2	3	4	5	6	7
13	Self-neglect	0	1	2	3	4	5	6	7
14	Disorientation	0	1	2	3	4	5	6	7
15	Conceptual disorganization	0	1	2	3	4	5	6	7
16	Blunted affect	0	1	2	3	4	5	6	7
17	Emotional withdrawal	0	1	2	3	4	5	6	7
18	Motor retardation	0	1	2	3	4	5	6	7
19	Tension	0	1	2	3	4	5	6	7
20	Uncooperativeness	0	1	2	3	4	5	6	7
21	Excitement	0	1	2	3	4	5	6	7
22	Distractibility	0	1	2	3	4	5	6	7
23	Motor hyperactivity	0	1	2	3	4	5	6	7
24	Mannerisms and posturing	0	1	2	3	4	5	6	7

அடிப்படையான உளவியல் மதிப்பீடு அளவு (கோல்)

0 = மதிப்பிடபடவில்லை,1= இருக்கவில்லை,2= மிகவும்லேசான,3= லேசான, 4= மிதமான, 5= அதிமிதமான, 6= கடுமையான, 7= மிகவும்கடுமையான

SL.NO.	SYMPTOMS	SCORE							
1	மனஞ்சாராத	0	1	2	3	4	5	6	7
2	கவலை	0	1	2	3	4	5	6	7
3	கிளர்ச்சியின்மை	0	1	2	3	4	5	6	7
4	தற்கேடாக தன்னைதானே கெடுத்துக்கொள்ளும்	0	1	2	3	4	5	6	7
5	குற்றத்தன்மை	0	1	2	3	4	5	6	7
6	பகைமை	0	1	2	3	4	5	6	7
7	ஊக்கமான மனநிலை	0	1	2	3	4	5	6	7
8	பெருமிதப்பகட்டான	0	1	2	3	4	5	6	7
9	அவநம்பிக்கை	0	1	2	3	4	5	6	7
10	மாயக்காட்சி	0	1	2	3	4	5	6	7
11	கட்டற்றநடக்கை	0	1	2	3	4	5	6	7
12	வழக்கத்திற்கு மாறான	0	1	2	3	4	5	6	7
13	எண்ண உட்பொருள்	0	1	2	3	4	5	6	7
14	தன்நிலை புறக்கணிப்பு	0	1	2	3	4	5	6	7
15	திசை குழப்பு	0	1	2	3	4	5	6	7
16	பொதுகருத்துதொடர்பான ஒழுங்குமுறைக்கேடு	0	1	2	3	4	5	6	7
17	கடுமுரட்டியல்பு	0	1	2	3	4	5	6	7
18	உணர்ச்சி பின்னடைவு	0	1	2	3	4	5	6	7
19	விசைபொறி சுணக்கம்	0	1	2	3	4	5	6	7
20	மனத்தாக்கலைவு	0	1	2	3	4	5	6	7
21	ஒத்துழையாமை மன எழுச்சி	0	1	2	3	4	5	6	7
22	கவனமாற்றம்	0	1	2	3	4	5	6	7
23	விசைபொறி ஆக்கம்	0	1	2	3	4	5	6	7
24	போலி நடை மற்றும் தோற்ற அமைவு	0	1	2	3	4	5	6	7

Steps Rehabilitation Centre (I)

Specialist in physical & Mental Rehabiliation

Coimbatore -45

1st June 2015.

Certificate In applied Art therapy for all

Certified that Mrs. P. Yamuna Devi underwent a course of study ART FOR ALL and successfully completed all the required for the issue of certificate during May 2015. She is eligible to work with people with mental disorders and children with Autism Spectrum Disorder. It is an indication that the said candidate has performed excellent in the coursework and has passed the course with Honors. We wish her continued practice in Art for All.

Karthik rajaram

Director

STEPS REHABILITATION CENTRE
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1850, Trichy Road,
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INDIA - 641 045.
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(A UNIT OF STEPS GROUPS)

INFORMED WRITTEN CONSENT

Investigator : P.YAMUNADEVI,

Name of Participant :

Age/sex :

Date :

Name of the institution : Institute of Mental Health.

Title : "A study to assess the effectiveness of art therapy among paranoid schizophrenia clients at Institute of Mental Health, Kilpauk, Chennai".

Documentation of the informed consent: (legal representative can sign if the participant is minor or competent).

- I _____have read/it has been read for me, the information in this form. I was free to ask any questions and they have been answered. I am over 60 years of age and exercising my free power of choice, hereby give my consent to be included as a participant in the study.
- I have read and understood this consent form and the information provided to me.
- I have had the consent document explained in detail to me.
- I have been explained about the nature of my study.
- My rights and responsibilities have been explained to me by the investigator.
- I agree to cooperate with the investigator
- I have not participated in any research study at any time.
- I am aware of the fact that I can opt out of the study at any time without having to give any reason

- I hereby give permission to the investigators to release the information obtained from me as a result of participation in this study to the regulatory authorities, government agencies and Institutional ethics committee.
- I understand that they are publicly presented.
- My identity will be kept confidential if my data are publicly presented.
- I am aware that I have any question during this study; I should contact the concerned investigator.

Signature of Investigator Signature of Participants

Date Date

INFORMATION TO PARTICIPANTS

Title **:** "A study to assess the effectiveness of art therapy among schizophrenic clients at Institute of Mental Health, Kilpauk, Chennai.

Name of the Participant :

Date :

Age/sex :

Investigator : P. YAMUNADEVI

Name of the institution : Institute of Mental Health, Kilpauk, Chennai.

Enrolment No :

You are invited to take part in this study. The information in this document is meant to help you decide whether or not to take part. Please feel free to ask if you have any queries or concerns.

You are being asked to Cooperative in this study being conducted in

What is the Purpose of the Research (explain briefly)

This research is conducted to evaluate the effectiveness of art therapy among paranoid schizophrenia clients at Institute of Mental Health Kilpauk, Chennai. We have obtained permission from the Institutional Ethics Committee.

Study Procedures

- Study will be conducted after approval of ethics committee
- A written formal permission will be obtained from authorities of old age home to conduct study.
- The purpose of study will be explained to the participants.
- The investigator will obtain informed consent.
- The investigator will assess the psychiatric symptoms level of each participant before the procedure using **BPRS** scale.

- The investigator will undergo training in art therapy training centre.
- Art therapy will be taught by the investigator daily. The procedure of Art therapy will be practiced to them with the help of pictures, crayons, color chalks, rangoli powders etc. Following that the level of psychiatric symptoms will be assessed after 10 days.
- **Possible benefits to other people**

The result of the research may provide benefits to the people and also empathetic care to them by investigator.

Confidentiality of the information obtained from you

You have the right to confidentiality regarding the privacy of your personal details. The information from this study, if published in scientific journals or presented at scientific meetings, will not reveal your identity.

How will your decision not to participate in the study affect you?

Your decisions not to participate in this research study will not affect your activity of daily living, medical care or your relationship with investigator or the institution.

Can you decide to stop participating in the study once you start?

The participation in this research is purely voluntary and you have the right to withdraw from this study at any time during course of the study without giving any reasons.

Your Privacy in the research will be maintained throughout study. In the event of any publications or presentation resulting from the research, no personally identifiable information will be shared.

Signature of Investigator Signature of Participant

ஆராய்ச்சி ஒப்புதல் கடிதம்

ஆராய்ச்சிதலைப்பு: மனச்சிதைவு நோயினால் பாதிக்கப்பட்டவர்களுக்கு கலை சிகிச்சை கொடுப்பதினால் ஏற்படும் திறன்கள்பற்றியஆய்வு.

ஆய்வாளர் பெயர் : பி.யமுனாதேவி

பங்கேற்பாளர் பெயர் :
வயது/பால் :
தேதி :

- ஆய்வாளர் மேற்கொள்ளும் ஆராய்ச்சியில்பங்கேற்க யாருடைய கட்டாயமுமின்றி முழுமனதுடனும் சுயநினைவுடனும் சம்மதிக்கிறேன்.
- ஆய்வாளர் மேற்கொள்ளபோகும் பரிசோதனைகளை மிக தெளிவாக விளக்கிக்கூறினார்.
- எனக்கு விருப்பமில்லாத பட்சத்தில் ஆராய்ச்சியிலிருந்துஎந்நேரமும்விலகலாம் என்பதையும் ஆய்வாளர் மூலம்அறிந்து கொண்டேன்.
- இந்த ஆராய்ச்சி ஒப்புதல் கடிதத்தில் உள்ளவிவரங்களை நன்கு புரிந்துகொண்டேன். எனது உரிமைகள்மற்றும் கடமைகள் ஆராய்ச்சியாளர் மூலம்விளக்கபட்டது.
- நான் ஆராய்ச்சியாளருடன் ஒத்துழைக்க சம்மதிக்கிறேன்.எனக்கு ஏதேனும் உடல்நலகுறைவு ஏற்பட்டால் ஆராய்ச்சியாளரிடம் தெரிவிப்பேன்.
- நான் வேறு எந்த ஆராய்ச்சிலும் தற்சமயம் இடம்பெறவில்லை என்பதை தெரிவித்துகொள்கிறேன்.
- இந்த ஆராய்ச்சியின்தகவல்களை வெளியிட சம்மதிக்கிறேன்.அப்படி வெளியிடும்போதுஎன் அடையாளம் வெளிவராது என்பதை அறிவேன்.
- எனக்கு இந்த ஒப்புதல் கடிதத்தின் நகல் கொடுக்கபட்டது.

ஆய்வாளர் கையொப்பம் **பங்கேற்பாளர் கையொப்பம்**

தேதி : தேதி :

ஆராய்ச்சி தகவல் தாள்

ஆராய்ச்சிதலைப்பு:மனச்சிதைவு நோயினால்பாதிக்கப்பட்டவர்களுக்குகலை சிகிச்சைகொடுப்பதினால்ஏற்படும்திறன்கள்பற்றியஆய்வு

ஆய்வாளர் பெயர் : பி.யமுனாதேவி

பங்கேற்பாளர் பெயர் :

வயது/பால் :

தேதி :

ஆய்வாளர் மேற்கொள்ளும் ஆராய்ச்சியில்பங்கேற்க யாருடைய கட்டாயமுமின்றி முழுமனதுடனும் சம்மதிக்கலாம். இதில் பங்கேற்பதன் நோக்கம். இந்த ஆராய்ச்சியில் தகவல்களை தெரிந்து கொள்வதற்காகவும். அதனை பயன்படுத்துவதற்காக மட்டும் தான்.

இந்த ஆராய்ச்சியின் நோக்கம்,மனச்சிதைவு நோயினால் பாதிக்கப்பட்டவர்களுக்கு கலை சிகிச்சை கொடுப்பதினால் ஏற்படும் திறன்கள் பற்றியும், கலை சிகிச்சைபயன்படுத்தும் முறைகளை பற்றி கற்றுதருவதும் ஆகும்.

ஆராய்ச்சி மேற்க்கொள்ளும் முறை:

இந்த ஆராய்ச்சியில் மனச்சிதைவுநோயினால் பாதிக்கப்பட்டவர்களிடையே உள்ள உறுதியான மற்றும் எதிர்மறையான அறிகுறிகளை கலை சிகிச்சைமுறைகளை கற்றுதருவதற்கு முன்புமற்றும்பின்புநோயாளியிடைய ஏற்படும் திறன்கள் பற்றி அறியலாம்.

இதனால் ஆய்வாளருக்கான பயன்:

இந்த ஆய்விற்க்குப்பன் மனச்சிதைவு நோயினால்பாதிக்கப்பட்டவர்களிடையே உள்ள உறுதியான மற்றும் எதிர்மறையான அறிகுறிகளை கலை சிகிச்சைமுறைகளை கற்றுதருவதற்கு முன்புமற்றும்பின்புநோயாளியிடைய ஏற்படும் திறன்களில் மாற்றம் உள்ளதா என்பதைப் பற்றி அறியலாம்.

இதனால்பங்கேற்பாளருக்கான பயன்

இந்த ஆய்வு மனச்சிதைவுநோயினால்பாதிக்கப்பட்டவர்களிடையே உள்ள உறுதியான மற்றும் எதிர்மறையான அறிகுறிகளை கலை சிகிச்சயினால் குறைக்கலாம்.

ஆராய்ச்சியில்பங்கேற்கவில்லை என்றாலும், உங்களின் சராசரி வாழ்கைமுறை, மருத்துவரின் ஆலோசனை மற்றும் சிகிச்சை முறையில் எந்த வித மாற்றமும் ஏற்படாது என்பதை தெரிவிக்கிறேன்.

இந்த ஆராய்ச்சியில்பங்கேற்க விருப்பம்இல்லை என்றால் உங்களின் முழுமனதுடன் நீங்கள் இந்த ஆராய்ச்சியில்இருந்து விலகி கொள்ளலாம் என்பதை தெரிவிக்கிறேன்.

இந்த ஆராய்ச்சியில் உங்களின் மருத்துவதகவல்களை பாதுகாப்பாக வைத்துகொள்கிறேன் என்பதை தெரிவிக்கிறேன்.

இந்த ஆராய்ச்சியின் தகவல்களை வெளியிடும் போது, உங்களை பற்றிய அடையாளங்கள் வெளிவராது என்பதை உறுதி கூறுகிறேன்.

ஆய்வாளர் கையொப்பம் **பங்கேற்பாளர் கையொப்பம்**

தேத ி: தேதி:

CERTIFICATE OF ENGLISH EDITING

This is to certify that the study conducted by Mrs. P.Yamunadevi, II year M.Sc. Nursing student, College of Nursing, Madras Medical College, Chennai – 3. On the topic " A study to assess the effectiveness of art therapy among paranoid schizophrenia patients at Institute of Mental Health, Chennai." has been edited by me for English language appropriateness.

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ART THERAPY

Introduction:

Art therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behaviour, reduce stress, increase self-esteem and self-awareness, and achieve insight. Art therapy integrates the fields of human development, visual art (drawing, painting, sculpture, and other art forms), and the creative process with models of counseling and psychotherapy.

Definition:

Definitions of art therapy vary due to its origins in two fields:

Art and psychotherapy. It can focus on the art-making process as therapeutic in and of itself ("art as therapy") or it can be “art in therapy” (art psychotherapy). The psychoanalytic approach was one of the earliest forms of art psychotherapy. This approach employs the transference process between the therapist and the client who makes art.

The British Association of Art Therapists defines art therapy as:

A form of psychotherapy that uses art media as its primary mode of communication. It is practiced by qualified, registered Art Therapists who work with children, young people, adults and the elderly. Clients who can use art therapy may have a wide range of difficulties, disabilities or diagnoses. These include, for example, emotional, behavioral or mental health problems, learning or physical disabilities, life-limiting conditions, brain-injury or neurological conditions and physical illness.

The American Art Therapy Association defines art therapy as:

The therapeutic use of art making, within a professional relationship, by people who experience illness, trauma or challenges in living, and by people

who seek personal development. Through creating art and reflecting on the art products and processes, people can increase awareness of self and others cope with symptoms, stress and traumatic experiences; enhance cognitive abilities; and enjoy the life-affirming pleasures of making art.

METHODS OF ART THERAPY:

Art as Therapy provides a safe space to explore "art for arts sake" in your own way. This can happen in an open studio setting with a little guidance or in a supported, structured class where you can learn different art skills. Engaging in creativity in this way can aid recovery as it helps you to focus, relax and express yourself.

Art Psychotherapy uses the creative process of making art as a safe way to represent your inner experiences, develop awareness and support personal change. Along with creating art, the art therapist may use relaxation and visualization techniques, guided imagery, music, movement and role play in the therapy session. This can help you cope with difficulties and stress, and speed up the process of your recovery. The Art Therapist offers a safe, supported holding space to allow a person to process difficult emotional issues.

HISTORY:

Although art therapy is a relatively young therapeutic discipline, its roots lie in the use of the arts in the 'moral treatment' of psychiatric clients in the late 18th century and in a re-evaluation of the art of non-western art and of the art of untrained artists and of the insane.

Art therapy as a profession began in the mid-20th century, arising independently in English-speaking and European countries. The early art therapists who published accounts of their work acknowledged the influence of aesthetics, psychiatry, psychoanalysis, rehabilitation, early childhood education, and art education, to varying degrees, on their practices.

The British **artist Adrian Hill** coined the term *art therapy* in 1942. Hill, recovering from tuberculosis in a sanatorium, discovered the therapeutic benefits of drawing and painting while convalescing. He wrote that the value of art therapy lay in "completely engrossing the mind (as well as the fingers)…releasing the creative energy of the frequently inhibited patient", which enabled the patient to "build up a strong defence against his misfortunes". He suggested artistic work to his fellow clients. That began his art therapy work, which was documented in 1945 in his book.

PURPOSES:

Art therapy may be provided for groups, or for individuals, depending on clients' needs. It is not a recreational activity or an art lesson, although the sessions can be enjoyable. Clients do not need to have any previous experience or expertise in art.

- The purpose of art therapy is essentially one of healing.
- Art therapy stands in contrast with other kinds of creative or expressive arts therapies that use dance, music or drama.
- One of the major differences between art therapy and other forms of communication is that most other forms of communication elicit the use of words or language as a means of communication. Studies have demonstrated the efficacy of art therapy.
- Another purpose of art therapy is determining existing disorders. Trauma, depression, schizophrenia, and PTSD are just a few mental illnesses that can be detected through art therapy.

APPLICATION:

As a mental health profession, art therapy is employed in many clinical and other settings with diverse populations. Art therapy can be found in non-clinical settings, as well as in art studios and in creativity development workshops. depending upon their individual qualifications and the type of licenses available in a given state. Art therapists may hold licenses as art

therapists, creative arts therapists, marriage and family therapists, counselors of various types, psychologists, nurse practitioners, social workers, occupational therapists, or rehabilitation therapists. Art therapists may have received advanced degrees in art therapy or in a related field such as psychology in which case they would have to obtain post-master's or post-doctorate certification as an art therapist. Art therapists work with populations of all ages and with a wide variety of disorders and diseases. Art therapists provide services to children, adolescents, and adults, whether as individuals, couples, families, or groups.

Using their evaluative and psychotherapy skills, art therapists choose materials and interventions appropriate to their clients' needs and design sessions to achieve therapeutic goals and objectives. They use the creative process to help their clients increase insight, cope with stress, work through traumatic experiences, increase cognitive, memory and neurosensory abilities, improve interpersonal relationships and achieve greater self-fulfillment. Many art therapists draw upon images from resources such as ARAS (Archive for Research in Archetypal Symbolism) to incorporate historical art and symbols into their work with clients. Depending on the state, province, or country, the term "art therapist" may be reserved for those who are professionals trained in both art and therapy and hold a master or doctoral degree in art therapy or certification in art therapy, obtained after a graduate degree in a related field. Other professionals, such as mental health counselors, social workers, psychologists, and play therapists combine art therapy methods with basic psychotherapeutic modalities in their treatment. Assessing elements in artwork can help therapists understand how well a client is in-taking information.

USES:

- "It's a good place to express creatively.
- It's good to relax.
- It's a non threatening environment.
- It's a non-competitive atmosphere and get support.
- It's the common ground that everyone else has a mental illness and there's no judgment."
- "it gives strong motivation
- To use this as a component in restructuring my life. The artistic and creative aspects are crucial."
- "it's helpful to get out and be creative and to have social interaction. It's as the name suggests – a place to be expressive and creative."
- "the art therapy and creativity has really helpful to grow and learn new things about themselves
- It helps to make the changes need to get better."